Branksome House

Branksome House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 12, 13 and 16 May 2016 and was unannounced. Branksome House provides accommodation and personal care for up to nine people with a learning disability, autistic spectrum disorder or mental health problems. There were nine people living in the home at the time of our inspection. Branksome House consists of a lounge, dining room, kitchen and nine bedrooms set over two floors. People had access to a secured back garden. Branksome House also provides staff to support a small number of people with their personal care who live in shared living accommodation or in their own homes.

A registered manager was in place as required by the service's conditions of registration. 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.

People were safe being supported by staff from Branksome House. They understood their responsibilities to protect people and report any concerns. People were relaxed and empowered around staff and were encouraged to make suggestions about their day. They were supported and encouraged by staff who were caring and compassionate towards them. People's dignity and privacy were respected. People who did not have family to support them were given opportunities to be supported by an advocate to speak on their behalf.

Detailed support plans identified people's risks, support needs and preferences. However, this information was not always consistently reviewed and updated, although staff were aware of changes in people's needs. Staff encouraged people to make choices about their day. They gained people's consent before they provided them with care. However the assessment of people's mental capacity was not always evident when people could not make a decision about their care and support for themselves. New support plans were to be implemented which would address the issue of consent to people's care and this was seen as an opportunity to review people's care needs.

There were sufficient numbers of staff to the meet the needs of people who used the services associated with Branksome House. Additional staff were provided if people needed support for appointments or community based activities. Staff had been trained and supported to carry out their role. All staff had been trained in similar subjects that allowed them to remain flexible and provide care and support across the service.

People enjoyed activities around the home and in the community. They were encouraged to eat a health balanced diet. Arrangements were in place to make sure people received their medicines appropriately and safely. However summary lists of people's current medicines did not reflect their prescribed medicines. The registered manager told us this would be acted on immediately. Where a person's mental or physical health well-being had changed it was evident that staff had worked with other professionals including the

community mental health team and occupational therapist to seek additional advice and support.

The registered manager and managers led by example and was supportive to people and staff. They had a 'hands on' approach and new people who used the services well. They valued people opinions and acted on any identified shortfalls. Some systems were in place to monitor the care and support people receive, however effective systems were not always used to monitor parts of the management and running of the home. A deputy manager had been employed to address this area. We have made a recommendation regarding the governance and monitoring systems of the home.

We found one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were cared for by staff who understood how to protect them from avoidable harm and abuse. Individual risks of people homes were assessed and managed.

People's medicines were mainly managed well and they received them safely.

People were supported by suitable number of people who were familiar to them. Staff had been checked and trained before they started to support people.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported and encouraged to make decisions and choices for themselves. However, the assessment of people's mental capacity to consent to their care was not always recorded.

People were supported with their personal care by staff who had been
trained and supported. Plans were in place to ensure all staff were regularly supported and appraised.

People were referred appropriately to health care services if their care needs changed. Where required people were supported with the planning, shopping for and preparing of their meals.

Is the service caring?

Good

The service was caring.

People's privacy, dignity and decisions were respected and valued by staff. They were encouraged to express their choices and preferences about their daily activities.

People told us that staff were kind and friendly. Staff knew people well and understood their different needs and adapted

their approach accordingly.

Is the service responsive?

Good

The service was responsive

People received care and support which was focused on their individual goals and needs. Their care records were detailed which provided staff with guidance on how they preferred to be supported. People had access to regular activities in the community.

People's feedback about the service was valued and acted.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Information about significant events had not been notified to the Care Quality Commission.

There were some shortfalls in the monitoring systems of the service; however, there were plans in place to improve the monitoring of the quality of service.

The registered manager and managers were approachable and supported staff. There was a strong sense of team work amongst staff.

Branksome 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 12, 13 and 16 May 2016 and was unannounced. The inspection was carried out by one inspector.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the service as well as statutory notifications. Statutory notifications are information the provider is legally required to send us about significant events.

Most people who receive care and support from Branksome House staff were unable to speak to us due to their complex needs. However, on 12 and 13 May 2016, we spent time walking around Branksome House and observed how staff interacted with people in the home. On 16 May 2016, we visited two shared living accommodations and spoke to two people who received support with their personal care. We also spoke by telephone to two people who received support with their personal care from Branksome House staff in their own homes.

During the inspection we also spoke with three members of staff and the three managers of the service including the care manager and the two owners of the service, one of which was the registered manager. We also spoke to three healthcare professionals who were linked to the service.

We looked at the care records of five people. We reviewed three staff files including recruitment procedures, as well as the training and development of all staff. We checked and discussed the latest records concerning complaints and concerns, safeguarding incidents, accident and incident reports and the management of the home with the registered manager.

Good

Is the service safe?

Our findings

People were kept safe from the risk of harm and abuse by staff who had been trained to recognise potential abuse and where to report it. Staff were confident that any concerns they raised would be dealt with appropriately by the managers of the service. They were able to tell us which external agencies they would contact outside the organisation if the managers did not act immediately. Polices which gave staff guidance on how to protect people and report their concerns were accessible to staff. The policies included contact details of CQC and local safeguarding authorities. The importance of safeguarding people was also reinforced and discussed at staff team meetings. One staff member said, "I would always talk to someone if I had any concerns. I wouldn't leave it." Another staff member said, "I would definitely report any kinds of abuse to a manager and record it. Definitely!" People also had access to an easy to read safeguarding procedure. This helped them to recognise signs of abuse and where to report their concerns.

People's health and well-being risks had been assessed and were being managed well by staff. Staff were knowledgeable about people's risks and how they should be supported to reduce harm to people. Some people had complex medical needs such as people who had seizures or who were at risk of choking. Staff had worked with external health care professionals when required to gain additional advice and support. For example, they had sought advice regarding one person who was at risk of choking. They had been given eating and drinking guidelines which were being followed by staff. Risk assessments were in place for people who needed support to mobilise and transfer with assistance or equipment. Records showed that an Occupational Therapist had visited and assessed one person whose strength and mobility had recently declined. Equipment had been provided to help staff to transfer this person. Training and photographic guidance had been provided to staff so they were fully informed of the techniques to use. Staff confirmed that they were confident in supporting this person to transfer using the equipment provided. Another person was also unable to move independently. Records and charts showed they were regularly checked and assisted to turn by staff to reduce the risk of developing pressure sores.

Records showed people's emotional and environmental risks had been assessed such as the risk of becoming anxious or road safety. People had personalised emergency evacuation plans to give staff guidance in the event of an emergency. Staff explained how they supported people who were known to become anxious or upset. People's support plans provided staff with information of the triggers or signs which may indicate they were becoming upset or frustrated. Guidance was in place to direct staff on how they should support people if their behaviour or emotions changed. People's emotions and behaviours were monitored and charted daily. This allowed staff to have an overview of people's mental well-being. We were shown examples of how the frequency of changes in one person's behaviour had instigated a referral to their GP. They were investigating into the possibility of hormonal changes which may be affecting their mood and emotions.

However, some people's risks were not consistently being reviewed and did not always reflect their present needs and risks. However, good communication between staff including daily hand overs, and the completion of daily notes about peoples physical and well-being ensured staff were fully informed of people's present needs. We were told the implementation of new support plans would address the

reviewing process.

At the time of our inspection there were sufficient numbers of staff to meet people's needs at all the services associated with Branksome House. Staff had remained flexible and carried out duties in other parts of the service where there had been unplanned staff shortages. All staff had received the same training as required by the provider and therefore were able to meet the needs of people who used the service. The care manager regularly reviewed the staffing levels to ensure there was sufficient staff to meet people's needs. Staff confirmed that there had been adequate numbers of staff to support people. Staff were offered additional shifts across the service where there had been a shortfall in the staffing numbers. When required, the managers also carried out additional care duties when there were staff shortages. We were told the home and associated services only used their own staff and did not use agency staff. This ensured people were cared for by staff who were familiar to them. The managers and team leaders also supported staff with an out of hours on call system which was used in the event of emergency or additional support was required.

Staff who supported people in their own homes told us their visit and travel times were realistic and achievable. They received a weekly rota of the care visit schedules. People told us staff mainly arrived on time and stayed for the full amount of time.

People were protected from being cared for by unsuitable staff. Recruitment processes were in place to ensure staff had been vetted prior to staff starting work for the service including employment and criminal history checks. References had been requested from their last employers to check the character and suitability of new staff.

There were safe medicine administration systems in place and people received their medicines when required. Most people received their medicines from blister packs. The quantity of medicines which were not stored in blister packs were checked regularly. Any discrepancies in people's medicines had been reported and investigated by the registered manager. A new medicines audit system had been put into place to monitor the safety and management of the medicines systems and practices. Protocols were in place for people who had known conditions or higher needs and may require prescribed medicines to be given 'as required' such as when they became anxious or needed pain relief. However, people's medicines summary lists and 'as required' list had not been kept up to date and did not reflect their current prescribed medicines. Three people did not have photographs on their medicine profiles. Photographs help to ensure staff give people their correct medicines. We found no impact on people as staff knew people well and they referred to the current medicines record charts where staff noted when people had been administered their medicines. The registered manager told us this would be addressed immediately.

Requires Improvement

Is the service effective?

Our findings

Some people who received care and support from services associated with Branksome House had complex physical and mental health needs and were unable to make significant decisions about their care. We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any condition on authorisations to deprive a person of their liberty were being met.

Staff and the managers had a good understanding of MCA. MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. They were knowledgeable about the importance of gaining lawful consent when providing personal care to people who were unable to make important decisions about their health and well-being. The managers and staff had acted in the best interest of people and put their needs first.

People's support plans gave staff guidance and prompted them to encourage people to make choices about their activities for the day. We observed staff giving people choices and supporting them to be as independent as possible. However, records of the assessment of people who had been considered as lacking mental capacity to make certain decisions about their care and support were variable and did not always relate to specific decisions about their care. We raised this with registered manager who recognised that some recordings of people's mental capacity assessments did not reflect their practices. They shared with us instances of how they had worked with people (who lacked mental capacity to make certain decisions), their families and health care professionals to come to a best interest decision on behalf of people. For example, one person was regularly supported by an Independent Mental Capacity Advocate (IMCA). An IMCA represents the best interest of people and may speak and work on behalf of people. The registered manager had worked with the advocate to ensure the person best interests had always been considered. They gave us an example of how they had supported a person to regain family contact as a result of a best interest decision between the advocate and staff.

The registered manager understood their role and legal responsibilities in supporting people in the least restrictive way. Where people needed to be deprived of their liberty, the registered manager had applied for authorisation to do this. People can only be deprived of their liberty to receive care and treatment when this in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff told us they felt supported by the managers and the registered manager of the services. They told us all the managers were approachable and provided informal support and advice on a daily basis and were always available. One staff member said, "I often work alone with people, but I know I can contact any of the managers if I have any concerns or problems. 24/7 we are supported if needed." Another staff member explained how they had been supported by the managers with personal issues as well as concerns about people and their changing needs. Staff told us they had received regular supervision meetings (1 to 1 formal

and private meetings with their line manager). Records showed that staff had the opportunity to discuss 'what was going well and what could be better' as well as their training requirements. However the frequency of the meetings was not consistently monitored. This was raised with the registered manager who stated whilst they knew staff received regular support meetings they had plans to implement a supervision matrix to monitor the regularity of staff supervision meetings. This would ensure all staff were regularly given the opportunity to meet privately with their line manager and discuss any concerns.

Plans were in place for the registered manager to meet with staff to carry out an annual appraisal of their work practices and review their personal development needs. The new format of the appraisal system was shared with us. It gave staff the opportunity to consider their personal development before receiving their appraisal interview with the registered manager.

Staff had been trained to carry out their role. Most staff had received training deemed as mandatory by the provider such as safeguarding and first aid. Staff were complimentary about the training they had received. One staff member said, "The training is very good here. We get plenty of it both informally and formally". Where people's health needs had changed staff had received additional specialised training. Staff were encouraged to develop in their role and undertake national vocational training in health and social care.

New staff had received a comprehensive induction programme before starting in their new role. This included training; shadowing experienced members of staff; reading people's care plans and documents relating to the home such as policies and procedures. New staff members were also required to complete an induction workbook which was reviewed and signed off by the care manager. They were also required to complete the new care certificate training which allowed the registered manager and senior staff to monitor their competences against expected standards of care.

The registered manager and care manager had completed a 'train the trainer course' and had subsequently delivered a series of in-house training to staff which included moving and handling, medication training and end of life care. Staff had also received specific training from health care professionals such as moving and handling training when supporting individuals.

People were given support to choose their meals on an individual basis. Food was cooked to meet people's individual taste and choices. In Branksome House, there was a two week rolling menu, however people could request alternative food if they didn't like the food options for the day. People who lived in shared accommodation or their own homes picked what they would like for their meals daily. They were supported to plan, shop and prepare their meals as required.

People's likes and dislikes in food and drink and their special diets were catered for. Staff were aware of the food preferences for people who were unable to communicate their favourite meals and snacks. People were given opportunities to suggest meal choices informally or during the home's service user meetings. People who spoke with us told us they enjoyed their meals and were encouraged to eat a balanced diet and maintain a healthy and stable weight.

People's support plans gave staff information about people's eating requirements such as the texture and size of their food and if they required assistance. People who had dietary and swallowing problems were provided with food in line with their eating and drinking guidelines provided by health care professionals. Where required, people's dietary and fluid intake was recorded and monitored to ensure people maintained a balanced diet. We observed people who required assistance to eat their meals being cared for in a dignified and respectful manner.

People were encouraged to maintain their general health and well-being. They had a health action plan which detailed how their physical well-being was monitored and maintained. For example, their health action plans included information about their dental, eye and hearing care as well as information about their medical conditions and gender screening checks. Staff supported people to attend health care appointments such as the dentist. Where people's physical and emotional needs had changed the service had made appropriate referrals to other health and social care professionals for advice and support. One health care professional said, "Staff are very responsive. They always support me on my visits to the home and follow through on any of my concerns. They do a good job."

Good

Is the service caring?

Our findings

People were at the heart of the service. The aims and objectives of the service were shared with people and their relatives such as 'To treat and respond to the individual as they wish to be treated and develop independently'. Staff confirmed that this objective was embedded in their practices and gave us examples of they supported and cared for people.

People were supported by staff who were kind and thoughtful about supporting people to have a good quality of life. People were treated as individuals and spoken to respectfully. When staff spoke with people they focused their care on each person's individual needs and preferences. One health care professional said, "I have nothing but positive comments about this home."

Staff knew people well and adapted their approach according to their emotional and communication needs. Some people required reassurance about their day, whilst others liked to have a friendly joke with staff. Staff spoke to us passionately about the people they supported. They gave us examples how they had supported people and made a difference to people's lives. The registered manager told us they were passionate about supporting people and wanted to ensure people lived a fulfilled life being supported by the service. They said, "We try to make people's lives as fulfilling and comfortable as possible." They went on to explain they were committed to support people through to their end of life where possible. They shared with us examples of how they had supported people during their last few days of their life.

Staff had taken time to support people to take positive risks, including trying out new activities and going on day trips. They told us about people's previous backgrounds and abilities and how they had worked with people to provide a stable environment and had slowly introduced new and regular activities. We were told about one person whose emotions were now being managed without the regular requirement of medicines. Another person's physical and mental well-being had significantly improved since their stay at the home.

People were treated equally and respectfully. Their decisions and choices were respected. We heard staff asking people about their choices of meals and how they would like to spend their day. On the day of our inspection of Branksome House, some people had chosen to walk to the local pub for a game of skittles and lunch with the support of staff. On another day, we met several people who lived in shared accommodation and were going shopping in the local town. Staff discussed with them what they would like to purchase. Staff arranged a taxi for people and supported them with their shopping trip. Their independence was encouraged and promoted. Staff had worked with people to develop their abilities and skills to be more independent with their daily activities and household chores.

We spoke to people who lived at Branksome House and people who received personal care support in shared accommodation and also in their own homes. They were all positive about the care they received from staff and the service. One person said, "I like living here. The staff are nice to me" Another person said, The staff are good. They always ask me how I am and have a chat. We talk about everything really. They are all lovely in their own way."

We observed staff interacting with people throughout our inspection. The service supported people who had a diverse range of physical, mental and emotional needs and different ages. Their human rights were met and respected. People were supported to have a private life and maintain contact with their families as they wished. Where people had no family to support them, the service had supported people to have advocates who supported them and acted on their behalf. People had the choice to freely move around their home and spend private time in their bedroom.

Support and consideration had been given to people who transferred to the service from another provider. Staff told us how they had worked with people to ensure they settled into their new accommodation and learnt about people's preferred support needs.

Good

Is the service responsive?

Our findings

People received care which was personalised and responsive to their needs. They were supported by staff who understood their backgrounds and preferences. People's needs had been assessed before they moved into Branksome House to ensure the home could meet their needs. Information had been sought from the person, their relatives and other professionals involved in their care. Information from assessments had informed people's support plans.

Each person had a support plan which detailed their support needs. This information provided staff with guidance on how each person liked their support and care. However, we found that some people's support plans and risk assessments had not been consistently reviewed and updated. We raised this with the registered manager who told us they had recognised that they were behind on reviewing people's care plans; however the implementation of a new format support plan would immediately address this. They shared with us an example of the new support plan format. They said, "Our aim is that everyone will have a new support plan in the next three months. This will give us a good opportunity to look at everyone's records and make sure all their paper work and records are up to date."

People's support plans were detailed and centred on people's individual needs and included information about their personal history and individual preferences. Details on how people needed to be supported with their care and social needs and their levels of independence were also recorded including their personal aims and objectives. People's progress towards these aims and an evaluation of the day were recorded and linked to their support plans. Each person had a health action plan which assisted staff to support people with their general well-being such as attending regular dentist, hearing and doctors' appointments as well more specialised health care services. A 'person centred plan' was also in place for each person. This provided pictures and a general summary of people's support needs such as information of people who were important to them and activities they required support with. One health care professional praised the staff for their 'fantastic record keeping'.

Health care professionals were positive about the care and support people received. One health care professional said, "The home is very responsive. Any concerns they contact us. Staff have a good relationship with the local GP and other health care services. I know people will get referred for extra support if needed." Each person had a keyworker who overviewed and monitored their care and support needs and goals and raised concerns when required. Staff were knowledgeable about the people they cared for. One staff member said, "I'm passionate about my work. They (people who use the service) always come first. It's not about me; this is their home they come first." Another health care professional told us "The service is responsive. The staff are not afraid to challenge and ask for help from other services and will also all go out of their way to be helpful to family and keep them updated."

The managers were working on a new assessment tool which would identify the progress in people's levels of independence and their achievement goals. Each goal was broken down into individual components and objectives such as their ability and motivation to make and attend a health care appointment. Their level of independence would be scored and monitored. We were told, "This 'smart' way of working will help us

identify where people are progressing and specific areas of support they may require."

Some people received support with their personal care in their own homes or in shared accommodation. New people were assessed in their home before the service started. The registered manager visited people and supported people with their personal care requirements for three days to assess and understand their needs. This information helped to form the persons support plan before the care team took over their daily support visits. All staff were introduced to people before they started to provide personal care. One person who received personal support and care in their own home said, "The staff are great. I can't grumble. I have no complaints." Another person said, "Yes the staff are fine. They look after me well and will watch out for any problems."

People were given opportunities to carry out activities in the home and out in the community. Their personal, social and recreational needs were being met. People had a timetable of activities which they had planned together with staff. They were supported to follow their interests and take part in social activities such as day centre, shopping and trips into the local community.

People's concerns and complaints were encouraged, explored and responded to. People's day to day concerns and issues were addressed immediately. People could also make suggestions and raise concerns in 'service user' meetings. The registered manager had recently sent out a quality assurance survey to people's families. People were also sent a pictorial survey to complete with staff. We noted the results of the survey were generally positive.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had informed the local authority where significant events which had affected people had occurred such as unexpected deaths and the outcome of the applications to request authorisation to deprive people of their liberty. However they had not informed CQC of these events. It is a legal requirement to inform CQC as this information is used to monitor the service and ensure the provider responds appropriately to keep people safe. The registered manager has subsequently provided CQC with this information but not at the time of the event.

The registered manager is required by law to notify CQC about any incidents that affect the health, safety and welfare of people who use the service without delay. This was a breach of Regulation 16, Care Quality Commission (Registration) Regulation 2009.

On a daily basis the quality of the service being provided was monitored by the shift leads and managers of the services being provided. Senior staff had been tasked with carrying out daily and weekly monitoring checks of the service being provided such as daily medicines audits and weekly financial audits and overviewing the care records relating to people. We were told that any shortfalls identified in the monitoring of the service would be raised with the registered manager and/or care manager who would immediately address the concern. This information also informed their action plan. The registered manager had also implemented a weekly medicines audit which would inform a monthly medicine audit and action plan. A quarterly audit of the services being provided to people had also been recently implemented and completed by the registered manager.

However, the monitoring of some areas of the management of the service was variable which had resulted in some inconsistencies in the running of the services. For example, whilst we found staff had been supervised and trained in their role, there were discrepancies in the frequency and recording of staff development and support. There were also no systems in place to ensure that documents relating to people's care records and risk assessments were consistently and regularly reviewed and updated in accordance to the provider's procedures.

We recommend the provider and registered manager seek and consider guidance from a recognised body around good governance processes and the management of the home and services being provided.

The registered manager was supported by two other managers who had level 5 Heath and social care qualifications. Together they overviewed the services and regulated activities associated with Branksome House. They were passionate about the support and care provided by the service. They were a role model to staff and demonstrated compassion and good practices when amongst people and staff. The managers provided support and advice to staff and people across all the services. They were knowledgeable about people who lived at Branksome House as well as those who received care from the service in their own homes and those who lived in shared accommodation. The registered manager had recently appointed a deputy manager. We were told the aim of employing a deputy manager was to highlight and implement more efficient management systems to monitor the running of the services.

The managers had a 'hands on' approach and were often involved in delivering care and support such as supporting people with health care appointments. We were told that the managers occasionally voluntarily provided care to people as part of the care team such as in the event of staff shortages or to better understand the needs of the people and to observe staff. We observed people confidentially talking to the managers and speaking about their day and plans. The managers were knowledgeable about people's past histories and how they had supported people when transferring their care and support from a previous provider.

The registered manager and managers kept themselves up to date with current practices and legislation by attending events, training and speaking to other health care professionals and colleagues. They cascaded any new learning to staff during staff meetings and in-house training sessions. They told us they had received a lot of support and guidance from the local authority Community Learning Disability Team (CLDT). They said "We learn a tremendous amount from the CLDT, especially when people's needs change. We ask for advice and support when needed. We are not afraid to ask."

Staff confirmed that the managers were always around the services and they were very supportive and could speak to them at any time. All the staff we spoke with said the managers of the service were approachable. They felt confident in the management of the home and that their opinions were listened to. Staff gave us example were their suggestions had been considered by managers and acted on.

Records were maintained when people had accidents or incidents detailing what had happened and when. The registered manager monitored accidents and incidents particularly those which were related to changes in people's emotions and behaviours. Action had been taken to prevent further harm or risks to people such as referrals to health professionals. Staff took the opportunity to discuss any incidents with the managers to identify if any further actions could have been taken to prevent an incident occurring.

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 Personal care	Regulation 16 Registration Regulations 2009 Notification of death of a person who uses services The registered manager did not notify CQC about the deaths of service users.