Willow Care Homes Limited

Willow Care Homes Limited - 116 Ashurst Road

Inspection report

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Date of inspection visit:
22 November 2018

Date of publication:
30 January 2019

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?	**Good**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 22 November 2018 and was unannounced.

Willow Care Homes Ltd – 116 Ashurst Road is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. This care home is registered to accommodate six people who have a learning disability. At the time of this inspection there were five people living in the home.

There was no 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. There was a manager in post but the provider had not put them forward for registration with the Care Quality Commission despite reminders that having a registered manager is a legal requirement.

Following the last inspection in September 2017, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions Safe, Effective and Well led to at least good. They failed to complete an action plan.

At our previous inspection of this service we found four breaches of legal requirements. These were because there were risks to people's safety resulting from a lack of safe fire procedure in the event of a fire at night and inedible substances not being stored safely. Some carpets were unhygienic and needed replacing, staff did not receive regular supervision and there was a lack of effective monitoring of the service by the provider. We checked these breaches at this inspection and found the provider had not made the required improvements and remained in breach of the same regulations.

The fire procedure to follow at night had been reviewed by the manager and discussed with the Fire Brigade after the last inspection but there was no clear guidance to night staff on how to evacuate each person safely. People's individual evacuation plans did not contain enough information to guide staff and they did not know what they would do in the event of a fire at night. The provider had not carried out regular checks of fire doors or fire alarm tests. Although cleaning products were now locked away other substances harmful to health if swallowed were in unlocked cupboards.

Some of the carpets remained in a poor unhygienic condition. The provider had not replaced them despite this being raised as a concern at the last inspection.

The provider had reduced night staffing two years ago and this had not been reviewed. There was no record of any risk assessment to state that one staff member could safely meet people's needs in the event of any emergency. The provider had not ensured staff were up to date with mandatory training. Other than three

staff attending first aid trading, the manager told us there had been no training provided in the last year. Staff had not received regular supervision. Despite the lack of training and supervision staff said they felt supported by the manager.

There was no evidence that the provider had carried out any checks or audits and did not have enough oversight of the home to identify the concerns we found. The provider did not have sufficient oversight of the home to ensure continued safe good quality care and had not made any improvements since the last inspection.

People living in the home had lived together for several years and got on well with each other and with staff. People's relationships with each other were important to them.

The care home was developed before the values underpinning Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. People living in this home were able to make choices about their lives, the activities they wished to do, the food they ate and their daily routines. Staff encouraged people to be as independent as they were able .People are supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Staff were kind and caring. People had weekly routines of attending day services and following their individual interests. They went out regularly, both as a group, and individually with staff to places they chose to go. People enjoyed a balanced diet and those who had swallowing difficulties had good support to eat safely. Staff followed good food hygiene practices.

Staff supported people well with their health and kept good records of their healthcare appointments.

Relatives thought the quality of care in the home was good. People living in the home, staff and relatives praised the manager of the home and thought they were doing a good job. Staff carried out monthly health and safety checks.

We served two warning notices on the provider for failing to comply with legal requirements. One legal requirement was about safe care and treatment and the other was about good governance of the home. The provider was given a date to comply with the warning notices and we will go back to check that they have complied. You can see what action we told the provider to take at the back of the full version of the 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?

Requires Improvement

The service was not consistently safe. The written guidance for staff to follow if there was a fire at night was not clear and did not tell them how to evacuate people safely. The provider was not carrying out fire safety training for staff, fire drills, regular tests of the fire alarm or checking fire doors which left people at risk in the event of a fire.

People had risk assessments addressing risks to their individual health and safety but some substances which posed a risk to people were not stored securely.

People received their medicines safely as prescribed. The carpet in the hallways, lounge and one bedroom was dirty, stained and unhygienic.

Is the service effective?

Requires Improvement

The service was not consistently effective. The provider did not ensure staff were up to date with mandatory training or provide any management training for the manager of the service.

Although staff appraisals had taken place there was a lack of regular supervision despite this being raised at the last two inspections.

Staff supported people with their nutrition and their health needs. Staff supported people at risk of choking by following the guidelines from professionals.

Is the service caring?

Good

The service was caring. People had good relationships with staff and with each other as they had lived together for many years.

Staff were caring and kind and encouraged people to make decisions and be as independent as possible.

Is the service responsive?

Good

The service was responsive. Staff knew and responded to people's needs and preferences. Four of the five people had a

weekly programme of day services and activities that they liked to do. The service had a car so that staff could drive people to their activities and people enjoyed their lifestyles.

Is the service well-led?

Inadequate

The service was not well led. There was no evidence that the provider had oversight of the service by carrying out quality monitoring which meant that there were risks that the provider had not identified and addressed, particularly in fire safety.

The manager oversaw the day to day running of the home and supported staff but had not received management training.

The provider failed to put in an application for the manager to be registered with CQC which is a legal requirement.

Willow Care Homes Limited - 116 Ashurst Road

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 checked 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 22 November 2018 and was unannounced. The inspection was carried out by two inspectors.

Before the inspection we reviewed all the information we held about this provider including previous inspection reports, notifications, correspondence and safeguarding information.

We met the five people living in the home. We spoke to three people and we spent time with everyone observing a mealtime and seeing how people interacted with staff and each other.

We met the manager and two care staff individually. We also spoke with another staff member on the phone. We carried out pathway tracking for three people. We read the risk assessments and care plans for the person then checked the daily records to see if the care plan and risk assessments were being followed. We also read the health and medicines records for those people. We checked finance records for one person.

Following the inspection we had feedback from two people's relatives and one health and social care professional.

We checked all health and safety, fire, maintenance and quality monitoring records. We checked menus and the speech and language therapy guidelines to support people to eat safely. We observed staff supporting two people at risk of choking to see if they followed the written guidelines for safe eating correctly. We

checked five staff files including their recruitment, training, appraisal and supervision records. We inspected the building including all bedrooms and communal rooms.

Requires Improvement

Is the service safe?

Our findings

People living in the home were at risk in the event of a fire. There was a lack of clear fire evacuation procedure for night time. There was not enough guidance for staff to follow in order to safely evacuate people. The guidance in four people's personal emergency evacuation plans (PEEPs) had not been updated since the last inspection and did not contain clear information about how to help the person to evacuate safely. The PEEPs referred to "white sheet protocol " that the manager told us at the previous inspection they did not know what that meant. No further guidance had been added since the last inspection. The fifth person's PEEP had been updated since the last inspection. The previous information had been crossed out with a pen and a written comment added telling staff to leave the person "stay put" and "inform the fire brigade". We discussed with the manager why they did not expect staff to try and evacuate this person. When asked about the "stay put" instruction the manager said that staff would try to evacuate the person but did not know how this would be done. There had been no consideration about how staff could evacuate this person, who was unable to walk, using equipment to help move them. Night staff confirmed they did not know how they would safely evacuate the people in the home.

The provider had not ensured that fire safety checks were carried out regularly in the home. The fire alarm had been serviced as required but the internal checks for fire safety had stopped taking place. Records showed that the weekly tests of the fire alarm had not taken place since 2 August 2018, so the provider did not know if the fire alarm was working properly. There had been no checks of the emergency lighting since 2 August 2018. The last record of the fire doors being checked to ensure they closed properly was 10 July 2017 despite us raising this as a concern at the last inspection.

The fire risk assessment stated that day staff would be trained in fire safety every six months and night staff would be trained every three months. This had not taken place. The last record of fire safety training was in February 2017. This meant the provider was not following their own fire risk assessment. The fire risk assessment stated that fire drills would be held every three months but the last recorded fire drill was in June 2017. The fire risk assessment had not been reviewed since March 2017 despite at least one person's needs having changed significantly in how they would be able to evacuate in the event of a fire.

One person's care plan stated that they were at risk of drinking harmful substances. At the previous inspection of the home in September 2017 there had been a breach of regulation as the cupboard containing chemical cleaning products was left unlocked and there was vegetable oil and a tin of thickening powder within reach. At this inspection we found the cleaning cupboard was locked but the vegetable oil and thickening powder were again within reach on a shelf and in an unlocked cupboard. We had informed the manager at the previous inspection of a medical alert about thickening powder which could cause death if accidentally ingested. This had been placed in a cupboard but was within reach and not locked up. This placed people at risk of harm.

There was a breach of regulation at the last inspection as carpets in the corridor, a bedroom and lounge were stained, worn and dirty. The carpet in one bedroom was ruched in two places which was a trip hazard and stained and dirty. A document in the person's care file stated that their carpet would be replaced in

2016 and their family had been told this would happen but the provider had not replaced the carpet. At this inspection we found the carpets to be more stained, dirty and worn than at our previous inspection. In the lounge the carpet had turned black in places where the carpet thread had worn away. The provider had taken no action to replace nor clean the carpets or to address the trip hazard due to the carpet in the bedroom. This left one person at risk of falling because of tripping on an uneven carpet. The carpets in their room, the ground floor corridor and lounge were unhygienic and therefore an infection control risk. Two staff, relatives and a visiting professional commented on the state of the carpets and one member of staff said they felt "ashamed" about the carpets.

Staff had recorded that bath water temperatures were taken regularly but there was no working thermometer available, the thermometer in the bathroom was broken. Despite this we tested the hot water and it was a safe temperature so there was no risk of scalding in the baths.

One person's bed was broken and staff had turned the mattress over so the person was sleeping on the side where springs could be felt through the mattress. The manager told us a new bed was needed but that the person needed a double bed and the provider would only pay for a single bed. The person did not have capacity to decide if they wanted to pay for their own bed and there was no evidence that a best interest decision had been made so the person had not been provided with a new bed.

The staffing level in the home was three staff during the day and two in the evening. At night there was one staff. There was no evidence that this had been risk assessed as a safe level of staffing to meet people's needs. People were at risk that their personal care and moving and handling needs and their safety in the event of an emergency may not be met at night.

All the above were a failure to assess the risks to the health and safety of people living in the home and to take action to mitigate the risks. This left people at risk of harm.

The above were a continued breach of Regulation 12 of the HSCA 2008 (Regulated Activities) Regulations 2014.

People had individual risk assessments identifying risks to their safety and advising staff on how to reduce those risks. Risk assessments addressed risks such as choking, falls, drinking harmful substances, travelling in a car and managing money. Staff were aware of the risks for each person.

The home had not raised any safeguarding alerts since the last inspection and the manager said there had been no safeguarding concerns raised about anyone living in the home. The provider had no written safeguarding procedure. Staff had a good understanding of safeguarding processes and what to do if they suspected somebody was abused.

We checked one person's finance records and found the home continued to safeguard people's money and keep clear records to prevent financial abuse. Expenditure was clearly recorded and receipts for people's purchases were stored securely. Staff had access to some people's bank accounts via their debit cards and the provider had written to London Borough of Barnet to request that people be given appointees who were not connected with the home in line with best practice.

In four of the five staff files we saw there were no proof of identity documents on file. The other required documents such as references and criminal record checks were in place. The most recently recruited staff member had all the required documents in place. We advised the manager to ensure that the provider keeps all recruitment records available for inspection.

People had safe support with their medicines. Staff were not up to date with medicines training but despite this people received their medicines safely and as prescribed. The manager had assessed them as competent. The manager had introduced a new medicines audit system a day before the inspection. We found medicines administration records were completed appropriately with no gaps which indicated that people had their medicines. We counted stock and found no concerns. There were written protocols in place for medicines that were to be given only when required. Each person had a medicines profile which detailed the reason they took the medicine and possible side effects. There was a record kept of medicines ordered.

The kitchen was clean and suitable for food preparation. We checked bathrooms and toilets which were also kept adequately clean. Bedrooms were cleaned by staff and had suitable safety measures in place such as thermostatic mixing valves on the taps in the en-suite bathroom to prevent scalding, radiator covers and window restrictors to prevent falls from windows.

The electric wiring and emergency lighting checks were up to date but the gas appliances had not been tested since 2015 so were overdue. We informed the manager of this so that they could advise the provider to ensure this was done.

Staff carried out monthly health and safety checks including flooring, drains, electrics, hand washing, security, water, rodents, hazardous substances, the fridge, personal protective equipment, health records, risk assessments and accidents and incidents. There had been no accidents or incidents recorded since 2016. There was a record in one person's file that they had been found on the floor with a cut on their head which had not been recorded in the accident book though was recorded in their own file.

Requires Improvement

Is the service effective?

Our findings

The provider had not provided training to staff since the last inspection to ensure they were trained to provide effective care. Three staff had completed First Aid training which was arranged by the manager but they advised that no other mandatory training had taken place in the last year. No central record of staff training was made available to us. The manager did not have a record of which online training staff had completed. Staff files showed that four out of five staff were not up to date with mandatory training. The fifth staff member had completed the care certificate which is a nationally recognised care qualification online in 2017. An occupational therapist had trained staff in the use of a standing hoist which one person used. They had no other moving and handling training. Some staff did not have up to date medicines management training including one staff member whose training was eight years previously. There was no evidence that the provider had any oversight of staff training needs. A lack of up to date mandatory staff training leaves people at risk of being cared for by staff who may not be properly trained to meet their needs.

Despite this being raised as a concern and breach of regulation the previous inspection, staff were not receiving regular supervision. One staff member had no record of supervision for two years despite working alone on duty. The most recent supervision recorded for any staff was in February 2018. Staff did say that the manager was supportive and talked to them regularly to see if they had any concerns. There had been no appraisal since the last inspection. The manager said these were overdue but there had been some issues which meant that they were behind with supervision and appraisals.

The above were a breach of Regulation 18 of the HSCA 2008 (Regulated Activities) Regulations 2014.

People's needs were assessed and recorded in a plan of care which staff were all familiar with. People and their relatives said they were happy with the care they received.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under MCA. People in the home had DoLS in place but these had expired in May 2017. The manager had applied to the local authority to renew DoLS prior to the last inspection and was waiting for the assessments to take place.

The manager had records of best interest decisions where a person did not have capacity to make important decisions for themselves. Examples of these were one person moving to a ground floor room and whether or not to inform a person of bad news.

A relative told us that their relative in the home was able to state their needs and wishes and that staff listened to them and respected their decisions.

Staff supported people with their health needs and supported them to attend their medical appointments. The manager gave an example of where a person was unwell and they sought medical attention quickly for them. Staff followed the guidance of specialist healthcare professionals when needed. People had Health Action Plans but these were not all up to date. One person's Health Action Plan said, "I am mobile" when this was no longer the case. The manager agreed they would ensure these were up to date. There were good clear records of appointments with healthcare professionals and the outcome. Staff kept records of people's food and drink and other health charts where needed.

Staff supported people to have a balanced diet. People could choose their meals and if they didn't want the meal on offer we saw they could ask for an alternative meal. The food was freshly cooked and people told us they liked it. We observed a mealtime and saw people enjoying their meal. Those who liked takeaway food could have this when they wanted. One person helped with food shopping and cooking. They told us, "I like cooking dinner. I help them out."

Two people had detailed guidelines from a speech and language therapist to support them with safe eating and drinking as they were at risk of choking. We observed a mealtime and noted that the staff prepared each person's food and drink to the recommended consistency. Staff supported people to eat safely following their written guidelines and ensured the mealtime was quiet and unhurried for the people.

The premises were suitable in that there were two ground floor bedrooms and bathroom for people who could not manage stairs. The bathrooms were not decorated to a good standard but were functioning adequately. Some staff, visiting professionals and relatives commented that the building needed refurbishing. One person said, "The sight of the carpet is enough to put you off". This summed up people's views that the care was good but the premises were not maintained to a high standard.

Good

Is the service caring?

Our findings

Two people told us they liked the staff at the home. The others were not able to tell us but we saw that they were comfortable with staff and that staff treated them kindly. Two relatives also told us that they thought staff were very caring. One said, "He's been specially looked after well." Another relative said this home was the best place their relative had lived and that they were very happy there.

The people living in the home had lived together for many years, some had lived together in previous homes. They had very good relationships with each other which they said were important to them. They told us they were good friends and had known each other a long time. One person was no longer able to communicate but their best friend still communicated with them and showed them affection. People also got on well with staff.

There was a friendly calm atmosphere in the home where staff talked quietly to people and showed affection to them. Two people told us they were happy in the home and one told us the staff were "very nice" and that they "get on great" with them. People laughed and joked with staff during the evening.

The manager kept in touch with families by phone or email to let them know how their relative was. A relative confirmed to us that the manager kept them up to date, listened to their views and took good care of the person.

Staff knew people's cultural and religious backgrounds. They supported one person to attend a culturally appropriate service two days a week and a place of worship. They also supported people to maintain their relationships with each other and with their families and friends outside the home.

Staff helped people clean their rooms which were personalised with their own belongings and reflected their interests and personalities. People told us they liked the home.

People's privacy was respected. Personal care was carried out in private and discreetly. People went to bed when they wished and staff responded when people asked for support such as to have bath or go to bed. Staff encouraged people to be as independent as they were able and take part in daily chores such as clear the table after meals and help cook.

Staff told us they thought the standard of care in the home was good. One staff member said, "I do know it's not a palace but the people are dearly loved and well looked after."

A visiting professional said they found the staff always friendly and helpful and that they did not have any concerns with the quality of care and support to the person they had visited.

Good

Is the service responsive?

Our findings

Care plans reflected people's preferences as well as their support needs. One had not been updated this year but the manager said all care plans reflected people's current needs.

Four of the five people had a weekly programme of activities outside the home to suit their individual interests. People attended different day services and groups and staff supported them to follow their chosen interests. A relative told us, "Staff at the Willows make every effort for [X….] to have fulfilling days." People told us they liked going to their chosen activities and enjoyed going out one to one with a staff member to do their shopping or go for a meal.

One person had a limited opportunity to go out and take part in activities but staff had recently supported the person to attend a party and meet up with old friends. This person had developed health conditions and staff had been responsive to their changed needs by requesting specialist advice and equipment for the person.

The service had a car so that staff could drive people to day services and to other places when they wanted to go. Each person attended day services four days a week and on the days that they were at home staff supported them to do what they liked. People knew their own routine and told us about the places they went.

At the weekends when there was no driver, people went out locally to parks, shops, café or pubs or relaxed at home. Some people had televisions in their bedrooms so could choose whether to be in the lounge with others or on their own. Staff supported people with their hobbies in the home such as watching films or doing art.

There had been no complaints since the last inspection. There was a complaints procedure for people to follow. Relatives said they felt able to raise concerns and said that the manager listened to their views and acted on them.

Staff were not trained in end of life care and this was not needed at the current time. End of life wishes had been discussed with relevant people where appropriate.

Inadequate

Is the service well-led?

Our findings

At the last inspection in September 2017 there were four regulations breached, and at this inspection the provider continued to be in breach of all four regulations.

Despite reviewing the fire procedure, the provider had left people at greater risk in the event of a fire. They had not updated their PEEPs nor advised night staff how they should evacuate each person safely. They had stopped carrying out fire safety training, fire drills and fire safety checks and had no plan for how to evacuate a person who could no longer walk. There was no evidence that the provider had carried out any audits on fire safety or checked whether staff were carrying out the necessary fire checks.

There was no risk assessment about the provider's decision to have only one staff at night despite one person's needs increasing. There was no evidence that the provider had oversight of training and supervision for staff and there was therefore a lack of regular training and supervision.

The provider failed to act on a requirement notice regarding the poor condition of some carpets. We considered that this had now become a breach of Regulation 12 as there were safety concerns with the carpets.

The provider's failure to carry out monitoring in the home left people at risk of unsafe care as the provider had not identified the concerns we found. The provider also did not respond to reasonable requests for information from us when we contacted them to check progress with meeting the breached legal requirements.

There was no registered manager in place. There was a manager working in the home in the manager role for over a year but they had not applied for registration. We raised this with the provider at the last inspection in September 2017 and had reminded them since then that it was a legal requirement to have a registered manager. They had failed to put forward a manager to be registered. This was a breach of the provider's registration conditions and Section 33 of the Health and Social Care Act 2008.

The provider had no effective systems in place to assess and monitor risk and quality. There was no record in the home of any audits or checks carried out by or on behalf of the provider. There was no effective system in place to monitor the risk to people's safety in relation to fire. The provider had not identified that fire safety checks were not taking place since August 2018, had not checked fire safety records or carried out any checks of the fire alarm, emergency lighting or fire doors since then and had not reviewed the fire risk assessment in the last year to ensure it was up to date.

The provider had not provided the manager with any management training to equip them for the role.

There was no risk assessment or dependency tool to show why the provider considered that one staff member at night was sufficient to keep people with complex needs safe in the event of an emergency.

Following the previous inspection the provider failed to provide the Care Quality Commission with an action plan in accordance with Regulation 17(3) addressing how they would address the breaches of regulation that were identified. This is a legal requirement.

The failure to operate effective systems and processes to assess, monitor and improve quality and safety and to assess, monitor and mitigate risks to the health, safety and welfare of service users and staff was evidence of a lack of good governance. There was a lack of oversight of the running of the home, particularly of staffing issues and fire safety, maintaining records, staff training and supervision. There had been no quality assurance surveys sent to families or professionals in the last year.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff carried out monthly health and safety checks and the manager had oversight of medicines and finances.

The management structure in the home was one manager supported by two seniors. We met the manager and one senior who were experienced and knew people's needs well. They had a good working relationship with each other and helped to provide support for other staff. Staff said they felt well supported and listened to by the manager. Relatives of people living in the home also praised the manager who they said was very caring.

Care files contained relevant information about people's care.

Despite the above concerns at provider level, we found that staff in the home were caring, had good relationships with the people they cared for and people were happy living there.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured staff were suitably trained or supervised and had not carried out any recorded assessment of required staffing levels to ensure staff were deployed effectively.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Section 33 HSCA Failure to comply with a condition The provider was in breach of section 33 of the Health and Social Care Act 2008 by failing to have a manager registered with the Care Quality Commission.

The enforcement action we took:

Fixed Penalty Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to assess the risks to the health and safety of service users and to take action to mitigate the risks, particularly in the area of fire safety and suitable floor covering

The enforcement action we took:

warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not operate effective systems and processes to assess, monitor and improve quality and safety and to assess, monitor and mitigate risks to the health, safety and welfare of service users and staff. There was a lack of oversight of the running of the home, particularly of staffing and fire safety, maintaining records, staff training and supervision.

The enforcement action we took:

Warning notice.