Reminiscence Care Homes Limited

Somerset Villa

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 10 and 12 May 2016 and was unannounced.

The home had a registered manager. 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.

Somerset Villa provides accommodation and personal care for up to 16 older people, some of whom may be living with dementia. On the day of our visit, there were 13 people living at the home.

At this inspection we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The staff knew how to support people to make day to day decisions about their care. However, the principles of the Mental Capacity Act had not always been followed when some decisions had been made on behalf of people. Some people were being deprived of their liberty without the required Deprivation of Liberty Safeguards (DoLS) authorisations being applied for. We asked the registered manager to take action regarding this.

There were enough staff on duty to keep people safe, however there was not enough staff on duty to provide activities or respond to people's needs in a timely way. Some people had to wait for to receive the care they needed. People were provided with support to eat and drink, mobilise and for personal care.

Staff were kind and friendly towards people living at the home, people responded warmly to staff and relationships were positive. Visitors were welcomed in to the home and appeared at ease.

Some staff had received training on how to provide people with safe and effective care, but there were significant gaps in all staff being trained, or receiving updated or refresher training. Assessment of staff's competency had only been carried out informally and this was not documented. Improvements were needed to ensure staff understood their role in recognising potential harm or abuse and in protecting people.

People received their medicines when they needed them, but these were not always stored appropriately. There were some minor discrepancies in the records of the administration of medicines.

Improvements were needed to ensure staff had regular supervision and support in order to reflect on their practice and develop their skills. Appropriate pre-employment checks had been carried out for new members of staff.

People were happy with the food provided and were able to make choices about what they wanted to eat. Advice had been sought where people had dietary requirements.

The environment was not fully designed to promote people's independence and was not suitable for people living with dementia. The environment was in need of refurbishment

The registered manager ensured that people had access to appropriate healthcare. People were able to see a GP when they needed to and access support from community healthcare professionals.

People were not actively involved in planning their care, and plans lacked personal information about choice, routines and interests although staff had an understanding of these. Risks to people had been identified and assessed to reduce and mitigate potential harm.

There was not enough for people to do to occupy them. There was no planning of activities, these were limited to watching television or reading a newspaper. People were bored.

The governance systems in place were not effective at assessing and identifying improvements that were needed to the quality and safety of the care that was being provided. Areas that had been identified as requiring improvement, such as the provision of activities, had not been addressed.

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.

Not all staff were able to recognise or respond to signs of potential abuse because they had not received the training necessary to do so.

There were not always enough staff to meet all of people's needs.

The home did not formally check the competency of staffs skills to safely administer medication.

Is the service effective?

Requires Improvement

The service was not always effective.

The principles of the Mental Capacity Act had not always been followed when decisions had been made on behalf of people about their care. Some people had been unlawfully deprived of their liberty.

The environment required improvement to help people orientate themselves within it.

People were supported to maintain their health and had enough to eat and drink.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were not always respectful to people when providing people with care and support.

Peoples views about how they wanted their care to be provided were not always sought.

People and their relatives thought that that staff were kind to them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People received the care they required but were not provided with opportunities to engage in meaningful activity.

Some people's care records contained inaccurate or conflicting information and were not person centred.

There was a complaints procedure in place.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The home did not provide a forum for people or their relatives to meet with the homes management.

The current systems in place to monitor the quality and safety of the service were not effective.

Staff were not supported in their role and they were not clear about their individual roles.

Somerset Villa

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 10 and 12 May 2016 and was unannounced. On the first day of the inspection, the registered manager was away, we spoke to them by telephone on the second day. The inspection was undertaken by one inspector and an Expert by Experience who has expertise in supporting older people living with dementia. An expert by experience is a person who has personal experience of using or caring for someone who use this type of care service.

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 reviewed this and also the information available to us about the home, such as the notifications they sent us. A notification is information about important events which the provider is required to send us by law.

We contacted the local authority quality assurance manager for information. We spoke with seven people who lived at the home, two relatives, the registered manager, three care staff, one senior care worker, the deputy manager, the home's maintenance worker, who was also a co owner of the home, and the cook. We looked in detail at the care records for four people, and referred to five other people's care records for specific information. We looked at the medicines management processes and records maintained by the home about staffing, training and monitoring the safety and quality of the service.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us that they felt safe living at the home. However, staff that we spoke with did not have a clear understanding of their responsibilities to protect people from the risk of abuse. They were not able to demonstrate how to recognise or effectively respond to a concern. We asked one senior member of staff what would they do if somebody reported a concern to them, and the registered manager was not available, they told us that they were not sure, and that, "They needed to find that out."

We asked staff if they had completed training in safeguarding people from abuse. One senior member of staff told us, "Yes, but quite a while ago." They were not able to describe to us what they learnt during the training. Another member of staff who had been working at the home for over a year told us that they had not completed safeguarding training, and could not describe to us forms of abuse or how to recognise them. The staff training matrix we reviewed confirmed this. According to the homes training matrix, of the 13 staff currently working at the home, five staff members had not undertaken safeguarding training, and three staff including the registered manager had not refreshed their training in safeguarding since 2010. The registered manager knew how to report a safeguarding concern, and to where they would report it. This meant that not all staff were able to recognise or respond correctly to signs of potential abuse because they had not received the training necessary to do so.

Staff we spoke to told us that if they were concerned about somebody living at the home, then they would talk to the registered manager about this. We reviewed the homes safeguarding policy and procedure, we saw that this was comprehensive, and contained details of who to contact within the local authority should a safeguarding concern need to be raised.

Risks to people had been assessed, for example we saw from the falls records that there had been several recent falls in the home. These had been recorded, the risk had been reassessed and people's care plans had been updated. Staff that we spoke with were aware of which people were at risk of falling, or who needed extra supervision and support when mobilising. We saw that when people did have accidents, then these were recorded appropriately, and contained the details of changes that were required and actions taken.

The registered manager ensured that required checks to the premises, such as for the fire detection system or for the servicing of equipment took place and provided us with records to confirm this.

However, during a tour of the home, we noted that a number of carpets had become very worn, and in some cases had rucked or torn causing a potential trip hazard. We saw that a fire escape in the conservatory area had a plugged in electric radiator blocking the doorway. This was brought to the attention of a staff member who took action to remove this.

People living in the home and their relatives told us that there were not enough staff to meet people's needs in a timely way. One person told us, "I am worried about the number of staff here, it takes two people to help me wash and dress and takes 20 minutes, what happens to the other people then?" Another person told us,

"Staff always say they will be back [with a drink] but there's always something else to be done, they are very short staffed here." They also told us, "Staff often say, 'I will see you later', but later doesn't come, or they say 'I can't do that now, I'm too busy', it's an eternal battle." A relative that we spoke with told us, "I have a good relationship with the owners and staff, but there are not enough of them." They also told us that they came in to the home to help their relative, because they felt that there was not enough staff to help them.

One person we spoke to told us that they felt that some staff's understanding of the English language was not good enough, and that those staff struggled to communicate with people because they didn't know what was being said to them.

Staff we spoke to told us that they felt there were enough staff to keep people safe but that more staff were needed to increase the activities that were offered. On the day of our inspection, there were three care staff on duty supporting 13 people. The home employed a cook who provided all of the catering. The staff rota we looked at confirmed that this was the usual number of staff on duty. The registered manager told us that they did not have a formalised system for calculating staffing ratios. They told us that if people did need 1:1 support then this could be provided.

We saw that staff could not always respond to people's personal care needs in a timely way, but were able to keep people safe. Although there were three members of staff on duty, we saw that people had to wait more than 10 minutes to receive support with eating and drinking at times. This was at periods when two members of staff were required to help somebody with personal care. The senior member of staff was responsible for duties such as completing medicines administration which meant that they were not always available to support people with personal care. We found that there were not enough staff available to meet people's other needs such as activities and engagement. During our inspection we observed that people either sat and waited at tables or sat in the lounge area watching television. Staff did not have the time to sit and have a conversation with people because they were too busy. Staff and people living at the home felt that there was enough support during the night and that call bells were responded to quickly.

Staff working at the home told us that they underwent a recruitment process when they started work at the home which included an interview, providing references and Disclosure and Barring Service (DBS) checks to ensure that they were a suitable person for the role.

We looked in detail at people's medicines. We saw that medicines administered on the morning of our inspection had not been signed to say they had been given for one person. We also observed one person receive a PRN, (as and when required) medicine at 10.30 am, but this was entered on to the person's records as being administered at 8am. The person's medicines administration record (MAR) stated that there should be a minimum of four hours between doses. This meant that there was a risk that this person could have received an over dose of this medicine. One person's MAR had an entry that meant that the person should not take a once a week dose of medicine that week, but we did not see a reason why. When we spoke to staff about this, they were not aware of why this had been entered on to the MAR. This meant that staff were not always accurately recording information that related to when people received their medicines, and there was a risk that people would not receive their medicines as prescribed.

Medicines were stored securely in a suitable cabinet in a dedicated room. However, we saw that some medicines were not stored in accordance with the manufactures guidance. We saw that one medicine that should be disposed of 28 days after opening, had not been. The date of when this medicine had been opened had not been recorded so staff were unable to determine when it should be disposed of. We could see from the homes medicines stock records that it had been issued from stock more than 28 days previously. We also found that this medicine was not labelled to show who it belonged too, and the

prescribing instructions were also missing. This meant that one person was receiving medicines that had not been stored correctly and that staff were sometimes administering medicines without the all necessary information that they required to do so safely.

Staff we spoke with told us that they had received training in the safe administration of medicines. However, when we reviewed the homes training records, we saw that of the nine staff currently administrating medicines, only five had received training during the past three years. The records showed that the registered manager last undertook training in this area more than eight years ago. The registered manager told us that they completed quarterly observations of staff competencies in the safe administration of medicines, but that this took place informally and no records of this could be provided.

Staff we spoke with told us that they found it difficult to administer medicines safely because the area used for the preparation of medicines was cluttered and messy with non-medicinal items such as toiletries. One staff member told us, "This room is a joke, we can't find anything." We observed used medication records on the floor of the room and shelving used for the storage of equipment contained items belonging to people that had moved out of the home or had passed away. For example, a thermometer used to take people's temperature via their ear, did not have any replacement disposable caps and was covered in ear wax. This was brought to the attention of staff who disposed of the equipment.

This meant that we could not be confident that people's medicines were managed safely and administered by staff that had the competency to do so safely.

We saw that medications requiring refrigeration were stored suitably, and that temperature checks of medicines cabinets and fridges were recorded daily. Regular stock checks were taken and the disposal and return of medicines were also recorded appropriately. Staff told us that nobody received their medicines covertly, and we observed staff explaining to people what their medications and obtaining their consent were before giving them. The registered manager showed us a recent audit of medicines undertaken by a commissioning authority pharmacist which made minor recommendations.

Requires Improvement

Is the service effective?

Our findings

Staff we spoke with told us that they had received training in areas such as food hygiene, managing behaviour and dementia awareness. Staff explained that when they started work at the home, they had received an induction period, in which they spent around a week shadowing experienced members of staff.

One member of staff told us that they felt that they needed more training, they said, "I need more knowledge to know more about the people I help, I need updated training." We reviewed the training records for this member of staff, and saw that although they had worked at the home for more than a year, they had yet to receive training in safeguarding, the MCA, first aid and supporting people with eating and drinking.

The home's training record provided to us by the registered manager did not contain any records to show that staff had completed eating and drinking training. We asked the registered manager about this and they told us that staff had not completed training in this area since 2012 because they had been unable to source a training course. The registered manager told us that staff had been supervised and assessed by them, and that they felt that staff were knowledgeable. However, there was no record of this assessment taking place, and the registered manager did not have a recognised qualification to do this.

We saw that there were significant gaps in staff member's training according to the home's records, for example in safeguarding and the MCA. The registered manager told us that they were currently trying to source further training to staff. This meant that staff had not completed all the training to ensure that people received effective care.

We asked staff about how they received supervision and guidance to do their job. All the staff we spoke with could not recollect having formal supervision or a team meeting. The registered manager told us that staff received supervision every 6-8 months, but that these were informal and not recorded. When we asked the registered manager if the home had a policy on staff supervision and support, they told us that they thought there was, but did not know where. We asked the registered manager to provide us with this if it could be located, but they were not able to do so. The registered manager told us that a full staff meeting took place every six months and was recorded. Records we reviewed confirmed this. From our observations and enquiries, we saw that staff did not receive effect support and supervision.

This is a breach of Regulation 18 of the Health and Social care act 2008 (Regulated Activities) 2014.

The Mental Capacity Act 2005 (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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We found that staff did not have an understanding of the MCA and the DoLS. One member of staff told us, "Couldn't tell you what it is, [registered manager] usually deals with it." All three members of staff we spoke with told us that they did not know what the MCA or DoLS was, and said that they had not completed training in this area. We reviewed the homes training matrix which confirmed this. Of the 13 staff currently working at the home, we saw that six staff had not completed training in this area.

We saw that in two cases, best interest decisions had been made and recorded in people's care plans, however, not all people who lacked capacity had been subject to an MCA assessment. For example, where people's medicines were being managed on their behalf, we saw that the person or anyone else had not been involved in making the decision. We could not see that people or their representatives were able to consent to the care and treatment they received. This put people at an increased risk of not being supported to make decisions or receive care in line with the MCA codes of practice

We checked whether the service was working within the principles of the MCA. Appropriate DoL's applications had been submitted for two people. However, we observed that a person was prohibited from leaving the home when trying to do so as both exits were locked with a key by staff. When we spoke to staff about this they told us that no one would be able to leave the building unless they had a key, or someone with a key unlocked the door for them. This person had not had a DoLS application made on their behalf. We spoke to the registered manager about this who acknowledged that an application for this person, and others, needed to be made and that they would take action to do so.

Staff told us that all people living at the home, except one individual, could only leave the premises with a member of staff. People had not had best interests decisions completed on their behalf to determine this. This meant that some people were at risk of being unlawfully deprived of their liberty.

We saw that staff offered people choice, for example when making somebody a drink. Staff waited for people to consent to support before providing this and told people what they were going to do.

We observed people eating their breakfast and their lunch time meal. People told us that they were happy with the food they were served although one person we spoke with felt that lunch was served too early at 12pm for people who preferred to have a late breakfast. When we spoke with the registered manager about this, they told us that people could choose to have their lunch later if they wished. We asked people what they thought about the food, one person said, "The food isn't bad, they ask everyday what we want to eat." We saw that two choices were offered at every lunch time, and we saw the home's cook go around and speak to people to let them know what the choices were, and that if they did not want this, or wanted a lighter option then this was provided.

We saw that people were encouraged to drink, and that drinks were served at fixed times regularly through the day, but soft drinks or water were not available to people at other times, or put on the table at meal times so that people could help themselves.

During the inspection we spoke to the home's cook. They explained to us how they created a balanced menu for people that was healthy. They told us they frequently spoke with people living at the home to gain their views, and that they regularly updated the menu as the population of the home also changed regularly. The cook also told us that they catered for people's individual needs including those relating to culture and religion. People who required their food to be fortified had this provided for them. We saw in peoples support plans that food and fluid intakes were recorded for those people that needed it to be. Assessments had been undertaken to establish how much people needed to drink to stay healthy. People who were at risk of losing weight were monitored and weighed regularly. People living at the home received enough to

eat and drink, and the food we saw provided looked appetising.

The home had identified when people were due for healthcare appointments and kept records of the outcomes of each appointment. People told us that they were able to see a doctor when they needed to. Each person living at the home had a detailed record of their health and how this was managed.

The environment and decor was not suitable for people living with dementia. This was because the colours were neutral and there were no contrasting colour differences between handrails, doors, walls and furniture. People living with dementia and with sight loss cannot always easily distinguish doorways and floors when there are no contrasting colours. This can have an impact of people's independence and their ability to move around the home independently. We saw there was some signage on doors of rooms. However there was no signage or cues to lead people to the outdoors, bathrooms and toilets or to different areas of the home and to encourage people to walk around the home and outside spaces.

We observed that many areas of the home had become shabby and worn, and carpets were in need of replacement due to excessive wear. There were areas of staining on ceiling tiles from previous leaks. The dining room and sitting room were open plan and adjoining, which meant that the environment was quite noisy and busy. The conservatory adjoining the lounge areas had doors that could be closed, but this area was only used by one person who had moved their own belongings into the area, so was not available for other people to use, or to spend time with their visitors in a more private setting. The home did not have a designated area where activities could take place without disturbing others. There was an outdoor area planted with shrubs that people could use if they wished.

Requires Improvement

Is the service caring?

Our findings

We were told by the people who lived at the home that the staff were caring and helpful. One person told us, "I have nothing but the highest regard for my care in this home." A relative told us, "I have observed nothing but professional care here, I am really pleased, they are really kind." Some of the staff had worked at the home for a long time and told us this had helped to get to know people well and build positive relationships with them. We observed people looked happy in the company of staff because they smiled and chatted with staff.

However, we heard staff refer to people using inappropriate terminology such as 'doing him' when describing supporting someone with personal care. This was impersonal and task orientated. We also observed some staff chatting to each other when carrying out care tasks and not engaging with the person they were supporting, which did not demonstrate a respectful manner. We observed a member of staff supporting somebody to eat their lunch, however they did not always actively engage with the person and were looking at the television which was switched on in the lounge. We found that although staff were kind and gentle towards people living at the home, they were not always fully focussed on interacting with people in a way that was respectful because they were often distracted or disengaged.

We saw personal information relating to people's health needs had been displayed on the wall of the staff office. This was also an area where visitors would talk to staff. This meant that personal and private information was on display to people, and that people's personal information was not always kept confidential

Staff were able to explain the individual needs of people, their personal preferences and their characters. We saw they used this well in order to build a positive relationship with a person who regularly refused care interventions.

Most of the people we spoke with told us they couldn't remember being involved in planning their own care and did not know what was written in their care plan. Care plans did not show people's involvement in planning their care although people told us that staff did ask them on a daily basis and that they had a choice.

We saw people had made decisions about their care and these had been respected. For example, people told us they chose the time they got up, went to bed, whether they stayed in their rooms, or in communal lounges, where they ate and what they ate. This ensured they retained a degree
of control over their lives.

The registered manager told us that residents meetings did not take place, because most people at the home were living with dementia. However they told us that they had recently commissioned an independent satisfaction survey from a specialist provider, which would be better suited to obtain the views of people living with dementia.

People told us that staff respected their privacy and dignity. We saw that staff discreetly attended to people's personal care needs; asking them quietly if they needed to use the toilet. We also saw staff prompted people to close toilet doors if they saw they were open when in use, which protected people's dignity.

We saw that staff protected people's modesty when carrying out tasks such as hoisting people and ensured that their clothing was appropriately adjusted to protect their dignity. People had been supported to maintain their appearance and their personal hygiene.

We were told by relatives that staff were respectful when they visited. We heard staff talking with and providing support to visitors about matters of concern to them and updating them about their relatives care. Staff made visitors feel welcome and we observed them being offered refreshments.

Requires Improvement

Is the service responsive?

Our findings

One person told us that when they first came to live at the home staff had asked them how they wanted to be supported and what they could do for themselves. However, they did not feel fully involved in planning their care following this. They told us that they felt that their views would not be taken into consideration.

People's care records identified any risks and actions needed to reduce risks but they lacked personal information about choices, routines and interests. The review of care plans was not effective and out of date information was not amended. For example we saw that one person had been diagnosed with a mental health condition, however, the support plan had not been updated to reflect this and provide staff with the information they needed.

We saw that people were provided with support that met their basic needs. Staff knew people's needs well, and provided support with personal care and eating and drinking. People who needed support to move around the home were assisted to do so. We saw at times that people had to wait for their care. This was because of the three staff on duty, one of these was the senior member of staff, responsible for administering medication and other duties such as liaising with GP's or family members. We saw that some people required two staff to support them with personal care. This meant that at busy periods, such as mealtimes, there was no staff available to help people with eating and drinking, and people had to wait. One person we spoke to told us that they frequently had to wait when the asked for a drink. They told us, "They say they will be back, but there's always something else to be done, they are very short staffed here."

We spoke to staff about peoples support plans, some staff told us that they knew where they were, but did not have time to read them, except for one person who had challenging behaviour. Other staff told us that they read them as they were required to do so. We saw in the homes records that information regarding people's falls was regularly updated. A review of their risk assessment regarding this was completed each time. Peoples skin integrity was closely monitored, and community professionals contacted if required.

Some people expressed dissatisfaction with the lack of interesting things to do, one person said, "There is nothing to do here." A relative we spoke with told us that their family member did not have the opportunity to participate in activities. They said, "There is not nearly enough activity for the residents." Another visitor told us, "My [relative] used to sing, they don't have music like that here, there is no singing." One person told us that they used to enjoy sewing and knitting, but had not been offered this as an activity at the home. Staff told us that a volunteer from the local church visited periodically to play music and talk to people.

We observed during our inspection that no activities took place. We saw that most people slept or dozed throughout the day. Staff told us that people didn't want to do anything other than watch television or read a newspaper. However, staff also told us there was a lack of interesting and stimulating things for people to do. When we asked staff if there was an activities schedule that people could choose from, we were told that there used to be one several years ago, but did not have one now as they were so busy. Equipment such as art and crafts, reminiscence objects or card games were not available, and tables that people were sitting at did not have items that could interest or stimulate them. We observed that some people remained in their

chair in the lounge or dining room for the duration of our inspection. We found that there were not enough staff available to meet people's other needs such as activities and engagement. Staff did not have the time to sit and have a conversation with people because they were too busy.

Relatives we spoke with were concerned that there was a lack of regular stimulation and 'things to look forward to' on a daily basis. One relative told us that their family member had taken part in an art class at the home previously, which they really enjoyed, however, another event had not been arranged.

We spoke to the registered manager about the lack of activities that took place in the home. They told us that they recognised this as being a problem, and that they had unsuccessfully tried to recruit an activities co-ordinator. As a result of our feedback, the registered manager told us that they were going to review the way in which staff rotas and shifts were planned to enable additional staff time to co-ordinate activities. We found that people living at the home were not engaged in meaningful activity, and that the home did not make arrangements to plan for or provide stimulation to people living there. People did not receive care and treatment that reflected their preferences.

A complaints procedure was in place and available if people wanted it. Relatives we spoke with told us that they knew how to complain. We saw a clear process was in place for receiving and responding to complaints in a timely manner.

Requires Improvement

Is the service well-led?

Our findings

We received mixed feedback when we spoke to staff, people living at the home and their relatives about how the home was managed and run. A person living at the home told us that they felt that feedback that had been made to the registered manger was not listened to. They told us, "They are very authoritative and unbending if I make suggestions, they [registered manager] must have their own way." We were also told that the registered manager was, "Kind but didn't listen." Relatives we spoke to told us that the manager was kind and approachable. When we spoke with staff, they told us that they liked the registered manager, but felt that they were not approachable. They told us that when they had tried to provide feedback to them in the past, that they were not interested in what they had to say, or were 'stressed and snappy' and would not speak to them. Some staff told us that the home was not a happy place to work, and that people were tired and stressed at times.

Staff told us that they knew how to whistle blow, and would raise concerns to a body outside of the home, one member of staff told us that they would contact the CQC if they needed to. We reviewed the homes whistle blowing policy, we saw that it did not contain details of who staff could contact if they wanted to raise a concern. We did see however that this information was contained in the homes safeguarding policy. This meant that not all of the homes policies contained the information that they should.

Relatives and staff told us that the registered manager was very visible, and spent a lot of their time working directly with people living at the home, so knew them well. However, staff we spoke with could not tell us what the vision and direction of the home was. Staff told us that the management and running of the home very much rested with the registered manager. They also told us they were not required to be part of that process so were not involved in any drive for improvement. Staff said that they did not provide feedback to the registered manager on the running of the home because they were not asked to.

Systems were not in place to ensure staff received routine one to one sessions and staff felt unsupported. Team meetings did not take place frequently, and records we reviewed showed that meetings that did take place only cover a specific topic, and did not cover topics relating to the care and welfare of people living at the home. The manager told us that she met with staff on a weekly basis for a short meeting, but that this was not a formalised process and notes were not taken. Staff we spoke to could not recollect this meeting when we asked them if they participated in meetings. We concluded that meetings with staff and people living at the home did not enable effective communication and the sharing of information. Minutes from meetings that did take place did not provide information or a record of what was discussed. Peoples views were not taken into account and were not used to improve the service provided.

The registered manager had a system in place to conduct quality assurance audits, however, they told us that this had not been completed since August 2015, because the documents had gone missing. They told us that a new system had been purchased that would commence this month. The registered manager told us that they had continued to monitor and complete audits during this period, in areas such as infection control, medication and food hygiene. However these records were not available for us to review. The registered manager was aware through these audits that staffs training had lapsed in a number of areas, but

had not taken action to address this. They told us that they had difficulties in sourcing training for staff.

This is a breach of Regulation 17 of the Health and Social care act 2008 (Regulated Activities) 2014

The registered manager told us that they did not have a formalised process of regular engagement with people living at the home or their relatives, such as resident or relative meetings. They told us they regularly spent time talking to people and their families, and asked them how their experiences were. This took place on an informal basis. The registered manager told us they had recently commissioned a satisfaction survey to take place in the near future.

Discussions with the registered manager confirmed they knew when to inform us of incidents that had occurred in the home and when to share concerns of abuse with the relevant agencies. The registered manager was aware of when to send us a statutory notification to tell us about important events which they are required to do by law.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems and processes were not in place to assess, monitor, improve the quality and safety of the care provided or to mitigate risks to people's safety. Some records were not accurate or complete. Regulation 17 (1) (2) (a) (b) and (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received appropriate support, training, professional development to enable them to carry out the duties they were employed to perform. Regulation 18 (1) (2) (a).