Care Quality Commission

Sanctuary Care Limited

Beach Lawns Care Home

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

Overall summary

Beach Lawns Care Home provides accommodation for up to 82 older people who require nursing and personal care. On the day of inspection there were 81 people living at the home. There are four units in the home; Suite A and B are for people who require personal care, Sandford Unit is for people who require nursing care and Memory Lane is for people living with dementia. The accommodation is arranged in one building over three floors. In each unit there are communal areas including a lounge and kitchenette.

This inspection was unannounced and took place on 4 and 7 August 2015.

There is a registered manager in post but they were on a secondment for six months. 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. In

Summary of findings

the registered manager's absence, the deputy manager was managing the home. The deputy manager was being supported by a number of senior managers as well as the registered manager.

People told us that they felt safe but there were risks to their safety. People and staff told us that there were not enough staff to effectively manage the needs of the people. We were told by the registered manager, regional manager and deputy manager that historic budgets were the main source of identifying how many staff were required. There were no systems in place that identified staffing levels based on the needs of the people receiving support.

Staff were aware of their responsibility to protect people from avoidable harm or abuse and had received training in safeguarding. Staff knew what action to take if they were concerned about the safety or welfare of an individual. They told us they would be confident reporting any concerns to a senior person in the home and they knew who to contact externally.

The recruitment process followed good practice and the staff received comprehensive training. However, some staff felt they needed more in depth dementia training. There was good understanding of how to support people who lacked capacity to make decisions for themselves. However, records did not always demonstrate who had been consulted. They were not always assessing people based upon each specific decision. Staff supported people to see other professionals to help with their care. Staff supported and respected the choices made by the people.

People had a choice of meals, snacks and drinks, which they told us they enjoyed. The chef provided alternative options if the people did not want what was on the menu to ensure their preferences were met. However, records for what people had eaten and drunk were not always accurately maintained. The medication processes in the home were good overall.

People and their relatives thought the staff were kind and caring. We observed some positive interactions, but occasionally this was not the case. The privacy and dignity of most people was respected. People were encouraged to make choices throughout their day.

There were detailed care plans for all individuals including life histories. These plans had emerging person centred approach to them; this means that people were central to their care and any decisions made. The needs of the people were reflected within the plans and the staff had good knowledge about them.

People knew how to complain and there were good systems in place to manage the complaints.

There were quality assurance procedures in place, but the online up to date systems were not all shared with us. The systems shared with us did not always identify shortfalls. The registered manager had a clear vision for the home and had systems in place to communicate this. The home had been building links with the local community.

We found a breach 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 this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

There were not always enough staff to meet the needs of the people that used the service.

Staff understood how to keep people safe and who to tell if they had concerns about people's safety.

Risks of abuse to people were minimised because there was a robust recruitment procedure for new staff

People's medication was stored and administered correctly.

Is the service effective?

Requires improvement

The service was not always effective.

The registered manager and staff demonstrated understanding about making best interest decisions on behalf of someone who did not have capacity. However, this knowledge was not always applied because these were not always specific to each decision being made.

People were supported by staff that had comprehensive training. However, some staff felt they required more in depth training in certain areas.

People were supported appropriately to eat and drink, but the records were not always accurate.

People had appointments made to see other health and social care professionals, but staff levels meant these were sometimes cancelled.

Is the service caring?

Requires improvement

This service was not always caring.

People told us that they were well looked after and we saw that the staff were mainly caring but there were times when staff did not acknowledge the people.

People were involved in making some basic choices about their care.

Most people's privacy and dignity was respected.

Is the service responsive?

Requires improvement

The service was not always responsive

There were activities in the home, but sometimes these were cancelled due to activity staff helping with other things. Staff did not have the opportunity to support people with activities.

Summary of findings

People did receive care and support in line with care plans and most staff were familiar with them.

People knew how to make complaints and there was a complaints system in place.

Is the service well-led?

Requires improvement 

The service was not always well-led.

The service had quality assurance systems in place but they did not always identify shortfalls.

The registered manager had a strong vision for the home and most staff were supported effectively.

There was a strong presence of management around the home.

Links were being built with the local community.

Beach Lawns Care Home

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 4 and 7 August 2015 and was unannounced. It was carried out by two adult social care inspectors, a specialist advisor (a nurse with experience of working with older people and people living with dementia) and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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 looked at the information in the PIR and also looked at other information we held about the home before the inspection visit.

We spoke with 17 people that lived at the home. We spoke with the registered manager and 32 members of staff including support workers, registered nurses, kitchen staff, cleaners, maintenance staff and activities coordinators. We spoke with six visitors and with five health and social care professionals.

We looked at 17 people's care records and observed care and support in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at 10 staff files, previous inspection reports, staff rotas, quality assurance audits, staff training records, the complaints file and a selection of the provider's policies.

Requires improvement

Is the service safe?

Our findings

People were not always safe. People were not supported by sufficient numbers of staff to meet their needs. When one person was asked about staffing they said “That little one that was on last night (meaning a member of night staff), I don’t know how they can breathe.” Another person said “I felt they could do with an extra pair of hands. At night they are on the go all night.” This person continued by telling us about having to wait thirty minutes for help with personal care. We spoke with another person who explained there were a lot of new staff and that put pressure on experienced staff. They went on to say “I think they just need more staff really.” A final person said “There are only two [staff] to a floor and hardly enough for 80 people". The rota we were shown for the week confirmed two staff working on each floor. Following the inspection we were told there were 81 people at the home during the inspection.

A relative described to us their concern about witnessing a person become distressed because they were not being assisted to use the toilet. Another relative said “I think they are short staffed. Some of the things happen because staff are rushing around.” A third relative said “The staff are very good, a lot of people need one-to-one including [name]. Staff know [name] likes one-to-one time but it is not always available.” Following the inspection the provider told us one-to-one is provided in line with people's care needs.

Staff we spoke with said “We have two people who need transferring, that takes two people. Most [staff] stay late because they have so much paperwork to do.” Another member of staff said “Staffing is not good in general.” This staff member continued to explain they had brought it up with management and were told it was due to finances. Staff in Memory Lane said “We could do with more staff” and “when we have three things run more smoothly.” Another staff member in Memory Lane said “Sometimes we are really short and can be rushed.”

Following concerns from people, staff and relatives we monitored call bells; these were so people could ask for assistance. On the first day we heard call bells ringing and then they appeared to stop. A member of staff said “we turn them off at night because it keeps people awake”; but we observed the bells had gone silent during the morning. Staff had buzzers in their pockets to know when call bells were being rung. During the first day we observed four call bells taking over five minutes to answer; on one occasion the call bell had rung for 15-minutes. A staff member who responded explained they were new and could not assist with the task required because they had not received appropriate training. Following the inspection the provider confirmed the staff member could not assist because they had not been assessed as competent following training to provide support independently. This meant people’s needs were not being met in a timely manner. Throughout the second day call bells were answered promptly. We requested a print out of call bell response times; these were unavailable due to maintenance issues. Members of senior management explained call bell response times had not been used as a way of monitoring if staffing was adequate. We were told in future they were planning on using them to alleviate concerns of relatives.

At times, we saw people received no interaction for long periods of time in the main lounges. During a thirty minute observation one person became distressed for ten minutes; they were unable to express why due to their communication difficulties. No member of staff was present during the time they were upset. Another person was being assisted by an external social care professional to adjust their specialist seating. It took over thirty minutes for the professional to locate two members of staff to assist with a transfer from a wheelchair to specialist chair. There were no staff present until they came to assist with the transfer. In Memory Lane we observed there were no staff present in the communal areas when staff were assisting people in their rooms. This means there is a lack of staff to monitor areas and meet the needs of people.

Some relatives said they were concerned about the cleanliness of the home. One said “There is always a smell of urine everywhere.” Another relative said “You will probably find that you have to go and get changed. I have come here, sat down and got wet three times since March.” In one bedroom there was an extremely strong unpleasant odour. We spoke to a member of staff about the room; they said “It is really whiffy in here, without a shadow of a doubt.” Another bedroom had crushed biscuits all over the floor. There were beakers with cold drinks and hand towels left on hand rails on one of the floors. In places around the home there were dirty floors and tired paintwork. Staff said there were not enough cleaners and “sometimes you have to cut corners.”

Requires improvement

Is the service safe?

We spoke with members of management, including the deputy manager, registered manager and area manager, about concerns around staffing levels. Following the inspection we requested copies of staff rotas. These were not provided due to staff being on holiday. Members of management, including the registered manager, said that historical budget levels determined the staff being provided for each unit; they had no systems to identify staffing in line with the needs of the people. The registered manager explained they can be fairly flexible with staff and move staff around the units; every shift was assessed and staff were moved to where they were needed. The registered manager said "We definitely have adequate staffing". However, we found evidence that people were not always having their basic needs met promptly and some people were at risk by not being observed by staff. People we spoke with, their relatives and staff all stated there were not enough staff.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people told us they felt safe at the home and with the staff who supported them. Two people said they did not always feel safe. "I don't feel safe at night when there is only one [member of staff]." One relative said it was "Very safe." Another relative explained that they felt it was safe for their loved one, except when another person goes in their room at night. They continued to explain that due to an on going health condition the person was confused when going into their relative's room. Another relative said "I feel I can trust the staff and they know what they are doing." They continued to describe how the service had taken action to protect the person from falls and how it was made safer. A health and social care professional said "It is safe."

Staff told us that they received training in how to recognise and report abuse. Staff spoken with had a clear understanding of what may constitute abuse and how to report it. All the staff we spoke with were confident that any concerns reported would be fully investigated and action would be taken to make sure people were safe. Staff training records confirmed that most staff had recently received training in safeguarding. Where allegations or concerns had been bought to the registered manager's attention they had worked in partnership with relevant authorities to make sure issues were fully investigated and people were protected.

Care plans contained some risks assessments which outlined measures in place to enable people to take part in activities with minimum risk to themselves and others. There were moving and handling risk assessments and risk assessments about protecting people from skin breakdown for those that required them. In most cases these had been regularly reviewed. A staff member we spoke to correctly identified one person who was at risk of skin breakdown. They were able to correctly identify possible signs of abuse.

Risks of abuse to people were minimised because there was a robust recruitment procedure for new staff. This included carrying out checks to make sure they were safe to work with vulnerable adults including a criminal record check. A staff member confirmed they had gone through these checks when recruited.

People's medicines were administered by nurses or senior staff members who had their competency assessed on an annual basis to make sure their practice was safe. One person said "My medication comes on time, they give it to me but they stand and watch while you take it."

There were suitable secure storage facilities for medicines which included secure storage for medicines which required refrigeration. On the first day one medicine trolley was stored at the top of a stair case rather than its designated secure place. This meant that the medication trolley was not stored in line with best practice to ensure people's safety. We informed the deputy manager and by the second day it was rectified. We saw medication administration records including those that required additional security recording and medicines entering the home from the pharmacy were recorded when received and when administered or refused. This gave a clear audit trail and enabled the staff to know what medicines were on the premises. We checked records against stocks held and found a mistake about the disposal of a medicine. The nurse immediately made the necessary amendments.

Some people were prescribed medicines on an 'as required' basis and others were able to self-medicate. Where there was use of covert medication the correct systems were in place. This is where the person was not aware they were being given medicines. One person had medicines administered covertly. The person's representative, pharmacist and GP had been consulted.

Requires improvement

Is the service safe?

This meant the service had taken the appropriate action and acted in the best interests of the person and protected their health and welfare where they were unable to consent.

Requires improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. Staff had some understanding of the MCA and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. They confirmed they had received training and one member of staff said "Best interest decisions are made when the person doesn't have capacity to make the decision."

There were inconsistencies in how the service acted in people's best interest and ensured people's legal rights were upheld. A person had capacity and was consulted about resuscitation it was not recorded on the form being used; their relative and person confirmed that they had been consulted about their resuscitation wishes. This meant the wishes of a person about whether they want to be resuscitated were not accurately recorded; their rights in line with human rights had not been documented correctly. The deputy manager explained this was a form completed by the GP and so not the responsibility of the home. Therefore, it was not the home's responsibility to make sure documentation was accurate for this decision. The provider had a duty to make sure that paperwork from other agencies respected people's wishes and human rights.

In care plans there were completed mental capacity assessments; there was no indication what specific decisions or areas of care this related to. The provider had carried out a best interest decision for one person but the specific decision and area it had applied to had not been identified. There was reference to discussion with a relative which is good because people had been consulted. The MCA forms were titled consent to care and accommodation rather than being for a specific decision. We asked the deputy manager what this meant and they said it meant it was related to all the care being delivered rather than one decision. The MCA forms did not always contain information about who had been consulted. We spoke with the deputy manager, registered manager and regional manager about the recording systems being used and they explained it was a standard format used in their company. Therefore, the MCA, and where required best interest decisions, did not appear to be in line with statutory guidance designed to protect people and their human rights. MCAs should be specific for only one decision because capacity can fluctuate in a person. As a result, people were at risk of their wishes not being followed or their human rights breached.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. There were some people that had been assessed as lacking capacity; but we found no completed DoLS applications despite being in a home that has restricted exits. Therefore, even though the registered manager and deputy manager were completing applications and had some understanding of DoLS procedures they were not correctly applying the principals.. We spoke with the registered manager and deputy manager. They said that all the DoLS applications had been completed due to the people being supervised and unable to leave the home independently

Most people received effective care and support from staff who had the skills and knowledge to meet their needs. One person said "The staff are well trained here" and another person agreed. A member of staff said there is "Good training. It gives you the information you need." One staff member said they needed more training in dementia because many of the people they cared for were living with dementia. . They explained they had training in the past but not recently. In Memory Lane staff told us they had received dementia training which consisted of two days a week for six weeks. One said "It was really good and helped me a lot in understanding what dementia is and how to care for people." Another staff member said the training was "Fantastic".

Most staff received regular supervision and appraisals to support them in their professional development. One member of staff said that had a supervision this week and they had an appraisal once a year. The registered manager and deputy manager are nurses and able to deliver clinical supervision to the nursing staff.

Requires improvement

Is the service effective?

There were always qualified nurses on duty to make sure people's clinical needs were monitored and met in the nursing areas of the home. During our inspection district nurses visited people in the residential unit to manage specific nursing needs.

People said the food was good and they had regular drinks. One person said "The food is good here, there is a great assortment and you can have as little or as much as you like." Another person said "There are excellent staff in the kitchen. Meals are very good." A relative said "There is always a trolley with drinks in the sitting room if [they] want one."

People's nutritional needs were assessed by the provider to make sure they received a diet in line with their needs and wishes. However, evidence of people's food and fluid intake was not always up to date or accurate. This meant that staff did not know whether the people had adequate intake of food and fluid to meet their needs. The nurses were aware of how to assess dehydration and actions to take. The chef confirmed people's dietary needs were regularly reviewed with nurses and carers.

At lunch time people chose where they ate their meal. Staff and relatives were assisting those that required help to eat. People had different meals prepared if they did not like the options for that day. In Memory Lane some people were shown both available meals; this enabled the person to make an informed choice about which meal to have. We saw one member of staff sat and ate their meal with people; so people could be prompted and encouraged to eat their meal. We observed that it provided an opportunity for the staff member to interact socially with people in a relaxed manner making the mealtime more of a social occasion.

The home arranged for people to see health care professionals according to their individual needs. However, on one occasion staff levels did not allow people to access these appointments. We saw visits from a number of health and social care professionals. We spoke with one visitor who explained that on two separate occasions staff had called the doctor for their relative. This means staff had identified people's needs and appropriately contacted the doctor. One person had been referred to a falls team and another to an eye specialist. Where people had specific care needs such as a risk of skin breakdown or poor nutrition referrals had been made for the appropriate specialist. One member of staff said "We do make dental check-up appointments for residents (or their families do it), but we often have to cancel the appointments as there are no staff to take them. I had to cancel an appointment for [name] as we had no staff a month ago." Following the inspection the provider shared they had a record of only one recorded occasion an appointment was cancelled.

We recommend the provider seeks guidance on the Mental Capacity Act and Deprivation of Liberty Safeguards to ensure they are being applied correctly.

Requires improvement

Is the service caring?

Our findings

People were not always supported in a caring way. Some people said they were supported by kind and caring staff. We spoke with one person who said "Staff are kind and good." Relatives said "Staff are very caring and kind, they understand people", "Staff are definitely very caring." And "The day to day care is very good." We observed staff interact with people in a non-verbal way. For example, on one occasion a staff member held someone's hand to reassure them. On another occasion they gently led the person away whilst talking with the person and telling them what they were doing. However, we observed occasions when staff walked through communal areas and did not acknowledge or interact with the people who were sitting in the room.

A person said "They will do anything you want, to help you feel dignified, like covering you over and making sure that little is showing." Another person with a hearing impairment chose to write things down for staff. However, one person was brought to their room by staff after lunch to speak with us. This person still had food around their mouth and the staff member left without assisting them to wash their face; they did not have capacity to wash themselves. This did not show respect for this person's dignity as they then had to be speak to us with food around their mouth.

People told us they were able to have visitors at any time. Each person who lived at the home had a single room where they were able to see personal or professional visitors in private. We observed visitors were made to feel welcome. A relative said "People can come and enjoy themselves". A health and social care professional spoke to us about their visits and said, "They are always accommodating."

People made choices about where they wished to spend their time. Some people preferred not to socialise in the lounge areas and spent time in their rooms. Staff told us they knew some people preferred to stay in their rooms and this was respected. We observed staff supporting a person to make a choice about where they wished to spend their time. The person was able to say they wanted to be in their room. Another staff member said "Residents can get up when they like."

There were ways for people to express their views about their care. However, one person did tell us "We have never had residents meetings." This meant there were not formal places to express their views and have them recorded. Following the inspection minutes from residents meetings were shared with us. We found most people had their care needs reviewed on a regular basis which enabled them to comment on the care they received and voice their opinions. However, sometimes this involvement was not effectively recorded in their care plan.

Staff were aware of issues of confidentiality and did not speak about people in front of other people. When they discussed people's care needs with us they did so in a respectful and compassionate way. We saw staff knocking on people's doors before entering their rooms; staff showed respect to people's personal space.

Requires improvement

Is the service responsive?

Our findings

Some people were able to take part in a range of activities according to their interests. However, the activities were not always the choice of people and available for all levels of ability. We saw people participating in an exercise class during our inspection. Some people did not have access to the same activities. In one unit, some people were using tablet computers for an art activity. A person in a different unit said "We sat around, eight of us (last week or the week before) and discussed the Ipad. I haven't seen anything of it since then." A member of staff in the same unit as this person said "I have never worked with anyone with an Ipad in here." One relative said to us "The TV is on constantly, I would rather there was interaction than a TV that no-one watches, they fall asleep to the TV. Where are the activities? They employ one person for 80 people." They continued to say "Why should my [person] come downstairs when there is nothing." Following the inspection the provider told us they employ two activity coordinators; one full time and one part time. A member of staff said "We have no time for the residents; we have to rely on activity staff to take over any activity. Often there are no activities at the weekend." Another member of staff said "We used to enjoy this job and take (the residents) shopping, but now on this unit, they are so dependent on us, we cannot do it."

People had activity folders in their bedrooms, but some of these were out of date. We spoke to some people who knew when activities were going to occur. One person said "The activity coordinator has to take residents to hospital sometimes, so sometimes the activities are cancelled. I could go and do painting this afternoon. I am happy with activities. We have people in to sing every three months and we have manicures." We spoke to the registered manager about the activities. The registered manager explained that there is an emerging person centred approach; care is being designed specifically for each person to meet their needs and preferences. They said this involved changing the culture of the home; they had been working on this since they took over. They explained that members of the church came regularly to hold a service and during the elections the local parliamentary candidates had come to visit.

Care plans were personalised to each individual and contained information to assist staff to provide care in a manner that respected their wishes. The care plans provided specific information about individuals including life histories; one person's care plan was about their dietary needs and another person's was about their clothes. Most staff were able to tell us about specific people and what they liked and disliked. But staff struggled to provide details for specific people if they were new or had been temporarily moved to a different unit. Following the inspection the provider said staff could find information about people in their care plans. However, some charts within the care plans were not completed accurately; one person had incorrect food and fluid recorded on their chart. According to one person's food and fluid chart they had not had fluid for a long period of time; their relative visited and knew the person had drunk different drinks during that time. The provider acted after we informed them and shared the concerns with the local authority safeguarding team, the person's doctor and their relative because they recognised the person's fluid chart had not been kept up to date. Following the inspection, the provider said the relative had not recorded the additional drinks on the food and fluid chart.This meant people were at risk of not receiving the correct care because staff had not kept fluid recording up to date on the chart. Also, staff monitoring the care plans would not know whether adequate care has been given.

Most people received care that was responsive to their needs and personalised to their wishes and preferences. Most people were able to make choices about aspects of their day to day lives. One person said "What I ask for is done; all the staff are good, I am perfectly happy with the care I get." Another person said that they had everything they wanted. A third person said "I am a smoker and they will take me out within reason, to have a cigarette, they help me with anything I need."

Each person had their needs assessed by the home before they moved in; this made sure the home was appropriate to meet the person's needs and expectations. The deputy manager and registered manager explained how they assessed people's needs; where possible they go to their home to carry out this assessment. We saw a person recently moved into the home and staff were in the process of creating a care plan for them by collecting important information. This showed people had their care needs recorded as quickly as possible when they moved in.

People we spoke with knew about the complaints system in the home. One person said "There is a notice on the

Requires improvement

Is the service responsive?

noticeboard if you want to complain." The home had a complaints folder; records of complaints showed they had been managed appropriately. This meant in a timely manner and when necessary there was a thorough investigation. When required, the registered manager had completed detailed responses and followed the provider's policy.

Requires improvement

Is the service well-led?

Our findings

There were quality assurance systems in place to monitor care and plan ongoing improvements. However, they did not always identify the improvements needed. An internal compliance visit to evaluate the home was carried out by the regional manager in July 2015. This did not identify the inconsistencies around the MCA; it was not consistently identifying issues. We saw where some shortfalls in the service had been identified action had been taken to improve practice. For example, when two people had falls in the same bedroom action was taken to level the floor and replace the carpet. We asked to see recent audits and checks that were in place to monitor safety and quality of care. We were shown audit files that were on site which showed a range of audits were carried out. However, some of these were out of date; there was a service improvement plan dated January 2014 and the care plan audit that should be completed monthly had none completed after March 2014. We were told quality assurance systems were electronic. Despite asking on a number of occasions the provider was unable to produce the most recent audits. This meant we were unable to determine if the provider was conducting sufficient and safe checks for all areas of the home.

There was a staffing structure in the home which provided clear lines of accountability and responsibility. This structure was displayed on a board near reception; so the people and visitors were able to view it. The registered manager was on a secondment but regularly had contact with the deputy manager and home. The deputy manager was being supported by senior management during this period. The deputy manager explained they were happy with the support that was being provided. People and staff we spoke with were aware of the staffing structure.

However, there were no clear systems in place to identify the number of staff required in each unit. We were told that historical budgets rather than support needs of the people were the main source of identifying staff levels. The deputy manager, registered manager and regional manager did not have any other systems in place to identify staffing levels. The registered manager felt the system was adequate. They explained on occasions where they had a resident with one-to-one care they get agency staff to help. Staffing levels were not adequate to ensure the care plans were always being followed; sometimes activities were cancelled.

The registered manager had a clear vision for the home and was working towards a person centred approach; a system of putting the person central in their care needs and wishes. There were staff meetings that provided opportunities to share ideas and daily meetings where information was shared about the people and the home. Staff told us they had supervisions; supervisions were an opportunity for staff to spend time with a more senior member of staff to discuss their work and highlight any training or development needs. They were also a chance for any poor practice or concerns to be addressed in a confidential manner. One member of staff explained they had difficulties working on night shifts so had been moved to day shifts. They were positive about the support that the management had shown during this time.

Members of the senior management, including the registered manager and deputy manager, appeared approachable and were visible around the home. One staff member said “I feel able to go to the manager if I have concerns. They provide good support and we have regular staff meetings.” Another told us “I have regular one to one supervision. I get the support I need.” However, some staff felt the managers were not approachable and they had not had regular supervision. This means that not all staff feel supported to carry out their work. As a result it may lead to people not receiving high quality care.

The registered manager was a registered nurse; they kept their skills and knowledge up to date through on-going training. They promoted learning and development for all staff in the home by providing training opportunities delivered in a variety of ways. Staff we spoke with confirmed the training was comprehensive; staff training records supported this. One member of staff said that they need more specialist dementia training in the residential units.

The registered manager and staff were working towards becoming more active in the local community. They described that local churches, schools and politicians now come into the home. They wanted to continue the use of

Requires improvement

Is the service well-led?

Ipads so that people could be in contact with their loved ones. The ethos of the home was aiming for people to have a good life whilst living there. We saw compliments cards and spoke with people and relatives that confirmed this.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Sufficient numbers of staff were not deployed in the service to meet the needs of the people. Regulation 18 (1).**