Kisimul Group Limited

Tigh Fruin

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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We carried out an unannounced inspection of the service on 30 January 2017.

Tigh Fruin provides accommodation and personal care for up to six people living with learning disabilities and an autistic spectrum disorder. At the time of our inspection there were five people living at the service.

Prior to our inspection visit we were informed that the registered manager was no longer 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. At the time of the inspection the registered manager had very recently left the service. The regional manager with the support of the assistant director for the organisation were managing the service. A new manager had been appointed and was due to commence employment in March 2017. We will monitor this.

Appropriate action was not taken in response to safeguarding issues. Staff had correctly reported safeguarding incidents to the registered manager, who failed to report these to the local authority safeguarding team or CQC. No analysis of incidents were completed to consider patterns, themes or lessons learnt.

Sufficient numbers of staff were on duty to meet people's needs during our inspection, however, systems were not robust to ensure that sufficient staff were on duty at all times. Consideration to the mix of staff with respect to skill, training and experience had not always been considered. Staff were recruited through safe recruitment processes.

There were systems in place to monitor and improve the quality of the service provided, however, they were not effective. People and their relatives were not involved or had limited opportunities to be involved in the development of the service. The provider was not meeting their regulatory requirements.

Risks associated to people's needs and the environment had been assessed and planned for. The provider had a policy and procedure for the use of physical restraint. Not all staff had received training in the restraint method used. Behavioural strategies to support staff to meet people's needs were more reactive than proactive.

People received their medicines safely.

Staff received an induction but training was not always provided in a timely manner. The staff training plan showed gaps in training and refresher training. Staff received opportunities to review their work.

The Mental Capacity Act 2005 was not fully adhered to. Menu planning was not routinely being used to

ensure people received an informed choice including healthy meal options. People were supported to maintain their health.

Staff were kind and respectful and knew people's needs. People and their relatives were not always fully involved in decisions about their care. Advocacy information was available to people.

People did not always receive personalised care that was responsive to their needs. Individual activities and opportunities were limited. Staff's knowledge and understanding of people's preferred communication methods was limited. A complaints process was in place.

We found four 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 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.

Appropriate action was not taken in response to safeguarding incidents. These had not been reported to external agencies as required and no analysis was completed to look at safety and how to reduce risks.

Risk plans associated to people's needs and the environment were in place.

Sufficient numbers of staff were on duty to meet people's needs during our inspection. However, systems were not robust to ensure that sufficient staff were on duty at all times. Consideration had not always been given to staff skill mix. Safe staff recruitment checks were in place.

People received their medicines safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff received an induction but training was not always provided in a timely manner.

The Mental Capacity Act 2005 had not always been fully adhered to.

People received sufficient amounts to eat and drink but there was a lack of menu planning. People were supported to maintain their physical health.

Is the service caring?

Good

The service was caring.

Staff were kind and caring and knew people's routines and preferences.

The involvement of people and their relatives were not consistent in decisions about the care and support provided.

Advocacy information was available for people.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive personalised care that was responsive to their needs. People were not always effectively supported with their communication needs.

People received limited individual opportunities to participate in activities of their choice.

A complaints process was in place and available to people.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There were systems in place to monitor the safety of the service provided, however, they were not effective.

People and their relatives received limited opportunities to be involved in the development of the service.

The provider had not met all their regulatory requirements however, they took action in response to the concerns once they had been identified.

Tigh Fruin

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 30 January 2017 and was unannounced. The inspection team consisted of one inspector and a specialist advisor in behavioural support needs.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information the provider had sent us including statutory notifications. These are made for serious incidents which the provider must inform us about. We also contacted the commissioners of the service, healthcare professionals and Healthwatch to obtain their views about the care provided at the service.

Due to people's complex needs associated with their autism and learning disability, we were unable to communicate with people to gain their views about the care and support they received. We observed staff interaction with people, but this was limited due to people being out or in their rooms for a large part of our inspection.

During the inspection we spoke with the regional manager, the provider's assistant director, a senior member of care staff and three care staff. We looked at the relevant parts of the care records of three people, three staff recruitment files and other records relating to the management of the service. Including medicines management and the systems in place to monitor quality and safety.

After the inspection we spoke with three relatives for their feedback about how the service met their family member's needs.

Requires Improvement

Is the service safe?

Our findings

Relatives told us on the whole they felt their family member was supported to remain safe. For some relatives Tigh Fruin was chosen as the most appropriate service due to it's size and environment, relatives said they felt these factors contributed to their family members safety. One relative said, "I feel [name of family member] is quite safe. They can have behaviours that can be challenging but not often. Staffing levels and the environment helps to make it a safe place." Another relative told us, "Up until recently I had no concerns about [name of family member]'s safety, on a visit I saw staff supporting a person with their challenging behaviour and I felt uncomfortable. I spoke to the registered manager who gave me strict assurance [name of family member] was safe and not in any danger. But within days I got a call to say [name of family member] had been hurt by a person who lived at the service."

At the time of our inspection we were aware that the local authority safeguarding team were investigating information of concern they had received, this investigation is still ongoing.

All staff spoken with said they were able to recognise safeguarding incidents and demonstrated their understanding and awareness. Two staff raised concerns that they had not received adult safeguarding training during their induction period. One member of staff said, "I've been in post six months and not had safeguarding training but I've worked in care before so I'm already aware of it, but new staff may not be."

We looked at the staff training plan that showed three staff based at Tigh Fruin had not received adult safeguarding training. The provider had a safeguarding policy and procedure that included the role and responsibility of all staff and the action required to safeguard people in their care. However, it is a legal requirement that staff receive safeguarding training to ensure they fully understand the action required to protect people from abuse.

The provider had a restraint policy and procedure and staff received accredited training to safely restrain people when required using least restrictive practice. However, the staff training plan showed two staff had not received this training. One staff member told us that they had been in a position where they had to support other staff to physically restrain a person without receiving appropriate training to do so. This was a concern because people had been placed at unnecessary risk due to staff being insufficiently trained.

From talking with the regional manager and looking at care records, we found that the frequency of a person's behaviour had significantly increased since November 2016. Staff had been correctly responding to these incidents such as recording and informing the registered manager. However, the registered manager had failed to take the correct action to safeguard this person and others. They had not adhered to the local multi agency safeguarding procedures by reporting safeguarding incidents. Neither had they informed CQC, a registration regulatory requirement or informed senior managers within the organisation. The registered manager had also not taken any action to do an analysis of the incidents for any patterns or themes or involved external healthcare professionals for any advice, guidance and support within a timely manner.

These were breaches of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

Relatives told us that they had no concerns about staffing levels. One relative said, "I have no concerns about staffing levels, I think everyone gets one to one staffing." Another relative told us, "I think staffing levels are generally good."

Staff raised significant concerns about staffing levels. They said that staffing levels had been less than required due to staff sickness and vacancies. Staff said that other staff from a nearby service within the organisation often supported but this affected people receiving a consistent approach. Staff said that staffing levels had recently been as low as two staff when it should be five and this had restricted what activities people could do. An example was given that a person had not been supported to go swimming for three months as a result of staffing levels. Records confirmed what we were told. Staff also raised concerns about the staff skill mix and said that due to not all staffing receiving specific training in restraint this had put people who used the service and themselves at risk. This told us that due to poor planning people were at risk of not being appropriately supported at all times.

We asked the regional manager about how staffing levels and deployment of staff were assessed. They said that people's dependency needs were assessed during the transition period and this information was used to determine staffing levels required. However, there was no system in place to show how people's dependency needs were regularly reviewed to ensure staffing levels were appropriate. The regional manager was unable to provide any staff rotas that would confirm what staffing levels had been or what future staffing levels were. We were not appropriately assured that adequate staffing levels were being provided. We asked the regional manager to forward us immediately a staff rota for the next month to confirm that sufficient staff were available at all times, to meet people's needs and keep them safe. This was provided as requested and confirmed appropriate staffing levels were provided. .

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were safe staff recruitment and selection processes in place. Staff told us they had supplied references and undergone checks including criminal records before they started work at the service. Records confirmed what we were told.

We received a mixed response from relatives about their involvement in discussions and decisions about how risks were identified, managed and reviewed. All relatives said during the transition period for their family member moving to the service, they were involved in discussions about how risks were to be managed. Not all relatives had seen their family member's risk plans to ensure they were in agreement with them. One relative said opportunities to meet with staff to discuss their family member's needs, including discussing and reviewing risk plans were poor. This lack of involvement by relatives or representatives was a concern due to the level and complexity of people's needs.

Individual risk assessments had been completed to assess people's needs and risk plans developed to inform staff of how to manage any known risks. These included needs associated with epilepsy and medicines, finances and activities within the service or externally in the community. We observed staff supported people as described in their risk plan. For example, when people were supported in a community activity they had the staffing levels as assessed as required.

The premises and environment internally and externally, was found to be secure to protect people's safety. Maintenance checks were being carried out internally and by external contractors and these were found to

be up to date. A business continuity plan and personal emergency evacuation plans were in place to inform staff of how to support people effectively, during an unexpected event that could affect the safe running of the service.

Relatives were positive about how their family member was supported with their medicines. One relative said, "They [service] have recently changed the system they use, medicines are now provided in pots already made of what's required so it's much safer."

We spoke with a senior member of staff who explained how medicines were ordered, stored, managed and surplus stocks returned to the pharmacy. We saw medicines were stored correctly and followed best practice guidance. Medicine Administration records (MAR) were used to confirm whether each person received their medicines at the correct time and as written on their prescription. We saw these had been fully completed and confirmed people had received their medicines correctly. We completed a sample stock check and found these to be correct. Staff had the required information to enable them to administer people's medicines safely. We observed a senior member of staff administer a person's medicine; they followed good practice guidance and remained with the person to ensure they had taken their medicine safely.

Systems were in place to check the management of medicines. We saw information that confirmed an audit had been completed by another registered manager within the organisation a week before our inspection. They had developed an action plan to address some shortfalls and this included completing competency assessments for staff responsible for administering medicines.

Some people preferred to take their medicines with food. However, it was unclear if this had been discussed and agreed with the GP and checked with the pharmacist to ensure the effectiveness of the medicines would not be compromised by giving it with food. The regional manager agreed to follow this up with healthcare professionals.

Some people had medicines prescribed for anxiety and behaviour to be used as and when required known as PRN. Staff had detailed information of when and how to provide these medicines.

Requires Improvement

Is the service effective?

Our findings

Relatives told us they felt staff were competent in meeting their family member's needs but none knew about the training staff had received apart from restraint training. One relative said, "Staff's ability seems good but I'm not aware of training they have received, it would be helpful to know." Another relative told us, "I would like to see more mature, experienced staff."

Staff told us they had received an induction but two staff told us they had not received training in certain areas that included safeguarding and the use of physical intervention. Records confirmed staff had received an induction at the commencement of their employment. One staff member had been employed at the service six months and another three weeks. One staff member said, "I'm experienced in care so have received training in a lot of areas but that's not the point."

The regional manager told us that the organisations training department provided staff with training in a range of areas such as, equality and diversity, risk assessments, health and safety, fire safety, infection control, first aid, communication and food safety. Training figures showed gaps in the attendance of all courses. Less than 50% of staff were recorded as having attended fire safety, risk assessments, food safety and infection control. Half the staff had received training in specific communication needs. This was a concern due to people's complex communication needs and preferred methods used to express themselves. We found staff had limited knowledge and understanding of how to support people effectively with their communication needs. The training plan did not show that staff had received training in autism awareness. This was a concern because all people living at the service were living with a learning disability and / or autistic spectrum disorder.

We asked to see training certificates to confirm staff's training, this was not provided, the regional manager said the training department did not provide staff with certificates. We spoke with the regional manager about staff not having received training during their induction period. They told us that they had recently identified this and that it was unacceptable and changes were being made to staff's induction and training.

Staff told us that they had received opportunities with their line manager to review their work but felt this was ineffective and a, "tick box exercise."

The regional manager sent us an action plan the day after our inspection to show that action had been taken to address the concerns identified with staff training. We will monitor this.

The Mental Capacity Act (MCA) 2005 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 checked whether the service was working within the principles of the MCA.

Relatives told us that they had been involved in discussions and decisions about specific decisions about their family member's care and support. One relative said, "In the beginning we were involved in discussions and decisions much more but anything specific we get asked our opinion." Another relative told us that the use of restraint used to manage any significant behaviour for their family member had not been clearly explained to them. They told us, "It came as a real shock to be told [name of family member] had been restrained by five staff. I'm aware [name of family member] can display behaviours but these have always been managed before [referring to a previous placement] without the need to physically restrain them. I've discussed this with the registered manager and the care plan and behavioural support plan have been changed. I'm just waiting to see them."

Staff showed an understanding of the principles of the MCA and DoLS. We found inconsistencies in how the MCA had been applied. For example, we saw MCA assessments had been completed in areas such as people not having the mental capacity to consent to the flu vaccination. Records demonstrated best interest decisions had been made with the involvement of others such as relatives. However, other MCA assessments had been completed for other decisions such as how people's medicines and finances were managed but best interest decisions did not show who and how these had been made. This meant that the MCA had not been fully adhered to. At the time of our inspection two people had an authorisation to restrict their freedom and liberty and applications had been made for other people in line with DoLS.

Training records confirmed some staff had received training in MCA and DoLs. The regional manager sent us information the day after our inspection to confirm additional MCA and DoLS training had been arranged for February 2017. The provider had a policy and procedure to support staff of the action to take to ensure they applied the principles of MCA and DoLs when required.

Some people experienced periods of high anxiety and behaviours associated with their mental health needs. There was a policy around the use of physical intervention including the model used; this stated it should be used as a last resort. The majority of staff were trained and could demonstrate the techniques taught. Staff also had a good understanding of distraction techniques and reactive behaviour strategies. One staff member said, "Redirection is the first port of call." However, staff had less understanding of personalised care planning and how it could be used proactively to avoid behaviours that challenged.

People had positive behaviour plans to support staff to know how to manage their behaviours. However, they listed possible behaviours rather than supporting staff to create environments where behaviour was less likely. Some of the management strategies were generic such as distraction or de-escalation and not personalised to people's individual needs.

Relatives told us that they felt their family member was supported to eat and drink sufficient and their food preferences were known and respected. One relative said, "Staff are aware of [name of family member]'s food preferences which is really important as they love their food and get a lot of enjoyment from it." Another relative told us that they had recently had a meeting with the registered manager to discuss meal options due to a concern about their family member gaining weight. They told us that they were confident staff were encouraging healthy eating.

We asked if there was a menu that was developed with people of what the daily choices of meals were. Staff told us they did not use menus but said, "It's just decided on the day." Staff told us that they tried to

encourage healthy eating and that people had snacks and drinks throughout the day. We saw people having drinks and snacks as described to us. Staff had been shopping during our inspection and we saw fresh vegetables and fruit was available.

We saw a person being supported in the kitchen at tea time. A staff member told us what the person's favoured food was and that they had the same meal every day. Whilst this respected the person's preference, we were concerned how this had started to affect their health. Records showed this person's weight had gained in the last few months. We spoke with the regional manager about this who agreed to speak with staff.

There lacked any planning and coordination in menu planning, food shopping and cooking of meals. This was a concern because people did not receive an informed menu choice and staff had no oversight of what people were eating. This meant there was a risk that people did not receive nutritious meal options.

Relatives were positive that their family member was supported with attending health appointments and that they were confident health needs were being met.

Care records confirmed people's health needs had been assessed and people received support to maintain their health and well-being. Healthcare professionals involved in people's care included speech and language therapists, a psychiatrist, GP and epilepsy nurse.

Good

Is the service caring?

Our findings

Relatives were positive that staff had a kind and caring approach. One relative said, "The staff are kind and look after [name of family member] well. When we visit the staff are friendly and welcoming." Another relative told us, "I like the fact that staff know [name of family member] likes, dislikes and their personality and mood. When they see [name of family member] staff show a genuine pleasure in seeing them."

Relatives told us that their family member had a named member of staff that was their keyworker. This meant staff had additional responsibility for people who used the service. Relatives said that they felt their family member had developed good relationships with all staff but in particular with their keyworker. One relative said, "[Name of family member] relates very well to [name of keyworker] I have confidence in them." This relative added, "I feel staff are caring and show a commitment in doing the best for [name of family member]." Another relative told us, "[Name of keyworker] is very fond of [name of family member] they are very caring towards them, they are similar age and like a surrogate me, I think it's more than just a job to them."

Relatives told us that there had recently been staff changes with experienced staff leaving. One relative told us, "We're not informed about staff leaving, some staff become like family members to people and it would be nice to know when there are staff changes."

Staff showed they had a good understanding of people's needs, preferences and what was important to them. There was some genuine commitment by staff towards the people they supported. For example, staff told us how they had worked unpaid on days off to provide additional support and had stayed with a person until the early hours when they were admitted to hospital due to being unwell.

A relative told us how staff had supported their family member to celebrate an important birthday. They said, "Staff made a real effort to make the day special and put on a buffet, I know [name of family member] enjoyed it and it made me feel good too."

We received a mixed response from relatives about how involved they were in meetings and discussions about their family members care. One relative said, "The last annual meeting we were invited to was in December 2015. We use to have regular telephone contact, but this got less and less, communication became very casual and we had to request a meeting last year but discussions didn't lead to anything." Another relative said, "I'm happy with how communication stands at the moment. It's still early days really." Another relative said they felt involved in their family members care but had not seen care plans or risks assessments or asked to be involved or give an opinion on them.

Information about independent advocacy support was available. An advocate acts to speak up on behalf of a person, who may need support to make their views and wishes known.

Whilst observations of staff engagement were limited during the inspection because people were out in the community or choose to remain in their room, we saw a member of staff knock on a person's door before

entering. We saw staff used people's preferred names and choices were given and respected in relation to meals, drinks and how people spent their time.

Relatives told us that there were no restrictions about when they visited. The importance of confidentiality was understood and respected by staff and confidential information was stored safely.

Requires Improvement

Is the service responsive?

Our findings

Relatives told us about the pre-assessment and transition experience for their family member. On the whole relatives were positive that this had been well planned and met the needs of their family member. One relative said, "The assessment and transition was excellent, well managed and was over a month which really helped the settling in period." Another relative said, "I was involved in the assessments and staff from Tigh Fruin visited [name of family member] in their different settings to get to know them. However, the transition didn't match the original plan; there were delays which was disappointing."

Relatives were positive about the environment and location of Tigh Fruin. One relative said, "The setting is great, it's a nice friendly village." One relative told us, "I think the living environment is a bit crowded now it's full but I know I can't change that and I would recommend it." Another relative said that their family member moved from another service due to Tigh Fruin offering a quieter environment.

After the pre-assessment, support plans were developed based on people's needs, preferences and routines. One relative said that their family member had a specific health condition and they felt staff were fully aware of this condition. We saw this person's support plan that provided staff with the required information to know how to respond to a change in this person's health.

We saw communication support plans had been devolved and included information about people's individual communication preferences. These included Makaton a form of sign language and Picture Exchange Communication System, [PECS]. This involves the use of pictures to communicate needs and choices. A relative told us about the communication preference of their family member and said they had some concerns that the tool they used was not easily accessible. They told us, "[Name of family member] has a communication book of symbols they use and an electronic talk pad which they can use confidently, but they need access to them and staff to promote the use of it."

We found that the environment did not include the use of any visual communication methods to assist people with their communication needs. A staff member said. "We have PEC boards to use but they're still in the box we don't know how to use them." In our observations we did not see staff use any type of communication tool other than spoken language. This was a concern as people who used the service had complex needs and had specific communication needs that they were not fully supported with. After our inspection the regional manager informed us they had arranged refresher communication training for staff in February 2017.

Relatives told us that they had provided detailed information about their family member's interests and activities that they enjoyed and was important to them. Records viewed confirmed what we were told. One relative said, "It's early days but staff have taken [name of family member] out walking and to the pub, it's amazing, really good." Another relative said, "[Name of family member] has a structured week, it's fall and varied." This meant staff had specific and personalised information about what was important to people to enable them to provide a responsive service.

Staff reported that activity timetables were not always followed and activities were frequently cancelled due to staffing difficulties. We found on display an activity timetable that showed the weekly activities that people were supported with. This was not individualised to each person and we noted the activity for the day did not match what people were supported with. Some external activities where accessed, such as horse riding. Staff told us that some people accessed a post 19 education service. This was provided within the organisations educational service they provided. Records confirmed what we were told.

The provider's complaints information was made available for people in an accessible format for people with communication needs. Staff told us and records confirmed that staff spoke with people about complaints in resident meetings. This meant people received an opportunity to express and share any concerns about the service. Records showed that one complaint had been received in the last 12 months which had been responded to and resolved.

Requires Improvement

Is the service well-led?

Our findings

We acknowledge that the provider took swift action to respond to the concerns identified at this inspection and they have provided us with an action plan detailing what improvements they plan to make. Prior to our inspection the provider had identified that concerns had not been escalated to them. Once the provider became aware of the concerns they took action to address them. At the time of our inspection two senior managers had taken over responsibility of the day to day management of the service. However we were concerned that the systems and processes in place had not been effective in escalating the concerns to the provider in a timelier manner.

The provider had systems and processes in place to monitor the quality and safety of the service. Some of these were completed by the management team within Tigh Fruin such as checks on the management of medicines, health and safety issues and support plans. The registered manager was required to report to senior managers within the organisation on a monthly basis. This included detailed information relating to incidents including physical intervention and behavioural statistics, staffing and staff supervisions.

We looked at the registered manager's monthly quality assurance report dated December 2016. We noted that the registered manager had failed to report the safeguarding incidents that had occurred. Whilst senior managers had not been made fully aware of the extent of difficulties staff were experiencing in managing people's needs, the summary of incidents reported for December 2016 showed a significantly high number of incidents. This should have alerted senior managers to have requested further information. We noted that actions in response to incidents included; "Reviews of support plans and risk assessments, regular activities were planned and increase the staff ratio." We found evidence to show that people were not supported with planned activities. This was because of the frequency of behavioural incidents that impacted on the availability of staff to support people effectively. Neither had staffing increased. This told us that the registered manager had failed to effectively use the systems and processes in place to monitor quality and safety. Senior managers had also not carried out appropriate checks on people's safety and well-being.

The provider had also failed to identify issues and concerns identified during this inspection. This included the gaps in staff training, the inconsistencies of MCA assessments and best interest decisions, the lack of menu planning and choice of meals, lack of person centred approaches to activities and opportunities and meeting people's communication needs.

People's support plans were not informed by any real functional analysis. For example, whilst a direct observation tool had been implemented to clearly record behavioural incidents that could be used to review and analyse behaviour, staff told us they were not being used. One staff member said, "I think I have seen one, but I have not been shown how to fill them in."

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that statutory notifications had not been sent to the CQC when required. We had not been informed

of safeguarding incidents.

This was a breach of Regulations 18 of the Care Quality Commission (Registration) Regulations 2009.

The regional manager told us that the quality team within the organisation completed three monthly unannounced visits to the service. We saw a report dated October 2016 that showed what action had been completed since the last audit and what further actions were required to improve the service. The regional manager also said that senior managers completed spot checks. The last unannounced spot check recorded was August 2016.

Relatives were positive about the service, one relative said, "I like Tigh Fruin because it's a small service, and has good facilities and ethos." Another relative told us, "It's excellent, as good as we could of hoped for, [name of family member] is safe and looked after." A third relative added, "On the whole I'm happy with the service."

Staff told us that they had not had confidence in the registered manager and that they felt unsupported. One staff member said, "Staff morale is low, communication has been poor and we've had no support or direction, staff have worked so hard, putting in extra hours we're exhausted."

Relatives told us that they had not been invited to any relative meetings or asked to give feedback about the service through surveys or questionnaires. We saw resident meeting records for January 2017 that showed people had been asked about food choices and activities. However, we saw no evidence that people's choices had been acted upon.

Staff told us that they should have had weekly staff meetings but this was not happening and was more monthly. The last staff meeting record we saw was dated 4 November 2016. This showed there was minimum discussion and actions about improvements required to the service.

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 Registration Regulations 2009 Notifications of other incidents Statutory notifications had not been sent to the CQC when required. 18 (1) (2) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Not all staff had received safeguarding training as part of their induction. Appropriate action was not taken in response to safeguarding issues. 13 (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems and processes did not effectively ensure people received a good quality and safe service. 17 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to deploy sufficient numbers of suitably qualified, skilled and

experienced staff to meet people's needs. There was no systematic approach to determine the number of staff required to meet the needs of people using the service and keep them safe at all times.

18 (1)