Family Care Private Company Limited

Bransfield Manor Care Home

Inspection report

Bransfield Manor Care Home
Church Lane
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Surrey
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Tel: 01883 742927
Website:

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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

Bransfield Manor is a care home that provides care and accommodation for 17 older people living with Dementia and mental health issues. On the day of our inspection 10 people were living at the home.

The inspection took place on the 23 and 29 October 2015 and was unannounced.

A registered manager was 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 a previous inspection in November 2014 the provider was not meeting the requirements of the regulations and we issued a warning notice for the concerns we found in the monitoring of service quality.

Summary of findings

We undertook a further inspection of the home in October 2015 to check that actions from the warning notice had been implemented and improvements had been made.

At this inspection we found staff did not show a level of understanding that people living with dementia have specialist needs. We did not observe staff consistently respecting people and treating people as individual's and focusing on their needs, abilities and achievements.

There were not sufficient numbers of staff to meet people's needs. People were left on their own in the lounge for periods of time which was a risk to their safety. We observed people being left unattended for periods of ten minutes or more.

Staff had written information about risks to people and how to manage these in order to keep people safe. However we did not observe that staff followed these guidelines when undertaking tasks such as helping people who had limited mobility to move.

Staff were adequately trained and this was observed in their approach to care and support of people. Staff did not always spend time with people in a social manner. We did not see many occasions when staff sat and interacted positively with people.

We identified that people had generally maintained weight however; people were not being appropriately supported in meeting their nutritional requirements particularly at lunchtime.

Care plans reflected people's current needs. The plans we saw contained clear guidance to staff about how they could meet people's assessed needs. However we observed staff did not always provide care and support as directed.

The legal framework around the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) had been followed. Staff we spoke with understood the requirements of the Act and how it affected their work on a day to day basis. The registered manager had completed the necessary MCA two stage assessments. Records detailed 'best interest' decisions and who had been consulted in making these decisions for people who lacked capacity.

Some DoLS applications had been made to the local authority, as required by the where a person's freedom may be restricted to keep them safe." For example being supported by staff to go out of the home.

Medicine procedures for the safe storage of medicines were in place. However we could not identify consistent best practice for the administration of medicines as we were unable to observe people being given their medicines, as people did not have lunch time medicines prescribed. .

People were at risk harm due to the lack of robust window restrictors in the home. The home had not followed best practice guidance for health and safety in Care homes as directed by the Health and Safety Executive (HSE).

The premises were not adapted to support the needs of people living with dementia. For example; had no signposting to peoples rooms or bathrooms; memory boards, orientation signage such as date and time displayed.

Staff ensured people had access to healthcare professionals when needed. For example, details ofdoctorsand opticians visits had been recorded in people's care plans. Complaint procedures were up to date and relatives told us they would know how to make a complaint if they needed to.

There were complete pre-employment checks for all staff. This included full employment history and reasons why they had left their previous employment. This meant as far as possible only suitable staff were employed.

The home had a satisfactory system of auditing in place to regularly assess and monitor the quality of the service. We found that the registered manager had implemented some systems to identify actions that were required to make sure improvements to practice were being made. The provider and registered manager had and continued to take action to address shortfalls identified at previous inspections to ensure that people received appropriate care.

The registered manager met CQC registration requirements by sending notifications when appropriate. We found both care and staff records were stored securely and confidentially

Summary of findings

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.

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 enough qualified and skilled staff deployed to meet people's needs.

Risks were assessed, with care plans and risk assessments providing clear information and guidance to staff. However staff did not always the best practice guidance in relation to people's assessed risks.

People were at risk because their medicines were not being managed appropriately in relation to 'as and 'when' medicine. Medicines were stored and disposed of safely.

Staff understood and would recognise what abuse was and knew how to report it if this was required.

All staff underwent complete recruitment checks to make sure that they were suitable before they started work.

Is the service effective?

Requires improvement

The service was not always effective.

Appropriate support was not always given to people in a timely way when they required support to eat and drink. People were not always offered choices of what they wanted to eat.

People's weight, food and fluid intakes had been monitored and effectively managed. However people were not supported at lunchtime in a way which suited their individual needs.

Staff understood their responsibilities under the Mental Capacity Act 2005. The appropriate forms had been submitted to the local authority where people who were unable to consent were being deprived of their liberty.

Staff had received regular supervisions.

Is the service caring?

Requires improvement

The home was not always caring.

Some people we spoke with were positive about the care they received.

People were not always treated with consideration and staff did not always interact with people in a respectful or positive way.

Some staff showed concern for people in a caring way; however practical action was not always taken to relieve people's distress.

Summary of findings

Is the service responsive?

Requires improvement

The home was not always responsive.

Care plans had been regularly reviewed to help ensure that staff had up to date guidance on people's needs.

People were not involved in the development of their care plans.

People were not always supported to take part in activities and we observed no individualised activities for people.

People were not given an opportunity to express their views about the care that they received.

Is the service well-led?

Requires improvement

The service was not always well led.

The service has a registered manager in place.

Staff said that they felt supported, listened to and valued in the service. There was open communication within the staff team and staff felt comfortable discussing any concerns.

The registered manager regularly checked the quality of the service provided and was working on issues identified to make improvements.

Bransfield Manor 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.

The inspection took place on the 23 October 2015. We returned on the 28 October as the registered manager was not present on the first day of our inspection.

The inspection was carried out by two inspectors.

We reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. We did not ask the provider to complete a provider information return (PIR) on this occasion.

During the inspection we spoke withthree people who lived atBransfield Manor, two staff, tworelatives, the registered manager, and the provider. We observed care and support in communal areas by using 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 a variety of documents which includedfour people's care plans,four staff files, training programmes, medicine records,duty rotas and quality assurance records. We also looked at a range of the provider's policy documents. We asked the registered provider to send us some additional information following our visit, which they did.

At the last inspection on the 11 and 12 November 2014, we asked the provider to take action to make improvements (for example care and welfare of people, and requirements relating to workers). We also issued the provider a warning notice in relation to a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At this inspection we identified the provider had taken action to address the areas of concern within the warning notice.

Requires improvement

Is the service safe?

Our findings

People told us the service needed more staff to help meet their needs. One person said, "You always have to wait a long time here for staff." A staff member said they did not feel people were at risk in the home from lack of care, but said if there were more staff more could be done for people to support them to have a "Quality day."

There were not always sufficient members of staff deployed to support people and meet their needs and this impacted on when people were able to get up in the morning or go to bed in the evening. On the day of our inspection two staff were on duty. The rota showed that this was the regular number of staff on a daily basis. A third staff member came on duty to support people at lunchtime. There were two waking night staff each night. The provider told us that they supplied staff on a basis of one care staff to six people during the day and at night two care staff to ten people. This was calculated on the number of people not based on people's individual level of need.

One staff member said that the night staff got five people up at 5:30 in the morning because the day staff did not have time to support everyone. They said "We start waking people up at 5.30 and everyone should be in the lounge by 07.00" and "At 9.30 night staff start putting people to bed, everyone should be in bed by 23:00". Staff said this was to relieve the workload of the morning staff, not because it was people's choices. We looked at the care plans for these people and saw that no one had expressed a choice to wake up this early.

The provider said that people health needs were deteriorating and that some people needed the support of two staff with personal care, to mobilise and transfer. On one occasion we saw one person trying to stand up from out of their chair unassisted, staff did not support this person although their care plan stated they were at risk of falls. Staff were busy transferring people into their wheelchairs with a hoist and taking them to the dining rooms which left people un-supervised. On the day of the inspection we saw times where people had been left on their own in the living areas for over ten minutes. Some of these people were at risk of falls and behaviours that challenged other people. This meant that whilst the two staff on duty were helping people with increased needs, the other people in the home were left unsupported.

In addition to providing care, staff were also required to cook suppers for people and to undertake cleaning and laundry tasks. Staff said this meant they could not dedicate their time to meeting people's needs. We discussed this with the provider, who told us they would recruit a separate housekeeper for the home.

There were not always enough staff deployed to meet the needs of people. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff recruitment records contained the necessary information to help ensure the provider employed people who were suitable to work at the home. Staff files included a recent photograph, written references and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. The provider had ensured that qualified staff had the correct and valid registration.

The premises were not always maintained, clean and suitable for the people who lived there. Relatives we spoke to said they liked the homeliness of the environment; one relative said, "It could do with a lick of paint." Another person said "It's an old house it needs a lot of up keep." People's rooms and communal bathrooms were not always clean. Skirting boards and windows were thick with dust, dirt and cobwebs. One person's room had a large patch of damp wall that had not been rectified. Window sills and paintwork were peeling and dirty.

Both baths had large areas of enamel chipped off and were rusting. The bathroom on the ground floor was very cold, the windows and sills were covered with cobwebs. Bathrooms and the toilets had not been hygienically cleaned on a consistent basis. We saw three commodes being used by people that were rusty and dirty, some with no lid. These commodes had not been clean and were soiled. We reported this to the registered manager, who informed us after the inspection that all commodes had been replaced.

Soft furnishings such as chairs were ingrained with dirt and had not been deep cleaned. Some people did not have plugs in theirs sinks, so would not be able to fill the sink to wash their hands or face.

We saw that two windows did not have the appropriate robust restrictors in place which could pose a risk to

Requires improvement

Is the service safe?

people's safety. These restrictors are to protect people from falling from height and should withstand foreseeable force applied by an individual determined to open the window further; and be robustly secured using tamper-proof fittings so they cannot be removed or disengaged using readily accessible implements (such as cutlery).

The premises were not always maintained, clean and suitable for the people who lived there. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that the registered provider was undertaking some remedial works and that a new walk in shower had been installed downstairs for people with reduced mobility to use.

There was an appropriate procedure for the recording and administration of medicines. We saw medicines were stored securely. Each person had a medication administration record (MAR) chart which stated what medicines they had been prescribed and when they should be taken. We observed staff ensuring people had taken their medicines before completing the MAR chart to confirm that medicines had been administered. We looked at a sample of MAR charts and saw they were completed fully and signed by trained staff. However people who were prescribed 'as required' medicines did not have protocols in place to show staff when the medicines should be given. For example; there were no protocols in place for people who were prescribed PRN paracetamol, another person was prescribed dietary supplements. There were no guidelines in place for when they required this.

We recommend that best practice guidance is followed in the assessing and recording of PRN medication.

Adequate risk assessments were not in place to identify some environmental risks such as surface temperatures (which should be reduced to 45°C), or radiator surface and pipes guarded to protect against contact. Carpets outside the ground floor toilet were lifting from the floor and stuck down with 'duct tape' which posed a risk to people with limited mobility. However the management of people's risks were dealt with in several ways. There were risk assessments in each person's care plan and these needed to be reviewed every month or sooner if required. One person was at risk of falls. There was information for staff on how to minimise the risk by being supported when they wanted to go for a walk. Other areas of risks assessed included pressure wounds and malnutrition. The member of staff said that these risks to people were also discussed at staff handover. However as described not all management of risks we followed by staff for example supporting people with their mobility needs.

Staff had knowledge of safeguarding adult's procedures and what to do if they suspected any type of abuse. Staff said that they would feel comfortable referring any concerns they had to the manager or the local authority if needed. There was a Safeguarding Adults policy and staff had received training regarding this. There were flowcharts in the offices on each floor to guide staff and people about what they needed to do if they suspected abuse. One staff member said "I would speak with the manager if a person wasn't eating or if they thought they were being abused, had bruising etc."

Accidents and incidents were recorded. Information was kept about what happened, who was involved, what documents had been completed, who had been informed and what actions were taken. The registered manager reviewed any trends that were identified from the records and steps were taken to reduce the risk of this happening.

There were emergency and contingency plans in place should an event stop part or the entire service running. Both the registered manager and the staff were aware and able to describe the action to be taken in such events.

Requires improvement

Is the service effective?

Our findings

One person said, “Food is good – probably too much. It is the same every week, so quite repetitive. I don’t particularly like that, but I haven’t asked for an alternative.” Another person said the food was good and you got what you were given”, they said “If I don’t like the main I can have a salad.”

People were not supported to have a choice about what they ate. We observed at lunchtime that some people were invited to sit at the dining room tables whilst other people remained in their chairs in the lounge to eat lunch. Lunch did not look or smell appetising and people were not offered a choice of meal or portion size. Most people were not offered a choice of drink and two people were not offered a drink with their meal. People did not have a choice of portion size; people could not help themselves to vegetables. Two people did not have a drink with their meal. In one person care plan it stated, “Likes to be offered two choices” however we did not see this happen.

Three people’s care plans stated they required full support to eat their lunch. One person care plan stated they required their food to be cut up in small pieces to encourage eating however this was not done. Another person’s care plan stated “Requires full support to eat and drink as cannot use cutlery.” This support was provided by only one staff member who was also supporting people that were walking around or needed support with their personal care. The people who required support with eating and drinking did not have the opportunity to have support that met their needs.

People were not always encouraged to eat and drink independently. The lunchtime environment was chaotic with people leaving the tables and walking around and there were not enough staff to support people to eat. Adapted cutlery and plates were not in use to encourage people to eat independently. Some people would have benefitted from using a plate guard. The local authority quality monitoring group stated, “It appeared that some people would have benefitted from aids such as plate guards to ensure they were able to eat easily on their own.”

Although people had been weighed regularly and referred to the Speech and Language Team (SALT) if their nutritional needs had changed. One person had been identified as needing nutritional supplements twice a day. During our inspection the person was not offered the supplements which were prescribed to boost their nutritional intake.

We recommend that the provider follows best practice guidance from NICE (National Institute for Health and Care Excellence) regarding Nutrition support for adults: oral nutrition support.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA). They aim to make sure people in care homes are looked after in a way that does not inappropriately restrict their freedom.

At our previous inspection we found breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation toconsent to care and treatment. The provider submitted an action plan to state they would meet the legal requirements by February 2015.

During this inspection we found that some improvements had been made to monitor and support people to make decisions in their best interest.

Many of the people living in the home were living with dementia. Some people had the mental capacity to make their own decisions on a day to day basis, but sometimes this fluctuated. Other people did not have the mental capacity to make their own decisions. Suitable arrangements were in place in the care plans we looked at for obtaining consent to care or treatment. We read in care plans that people’s consent had been obtained for care or treatment which meant people were being supported to make decisions and choices about their own care. One staff member said they would always let people make their own decisions about what they wanted to wear or what they wanted to do during the day.

We saw that people had bedrails in place and the external doors to the home were locked, this meant people were restricted from leaving the building. We saw some two stage mental capacity assessments which would help determine if a person lacked capacity to make a particular decision or if the use of bedrails was appropriate for the person. We spoke to the manager who stated that DoLS

Requires improvement

Is the service effective?

applications had been submitted to the local authority. We were told by the registered manager that these applications had not been assessed yet by the local authority.

People and relatives told us they thought staff were trained to meet their needs and their family member's needs. One person said to us, "The staff are very friendly." The registered manager told us that all staff undertook an induction before working unsupervised to ensure they had the right skills and knowledge to support people they cared for. One staff member said the training was really good and they had shadowed senior colleagues before working on their own. One member of staff told us, "I shadowed for three days, I had time to read care plans, this enabled me to understand people and communicate with them. I have had an induction, I have learnt the routine."

Where peoples health needs changed, staff acted quickly to ensure they received the support they required. We saw evidence that showed external healthcare professionals such as GP's, physiotherapist, and nutritionist had been contacted when concerns with people's health had been identified. Care plans contained up to date guidance from visiting professionals involved in people's well-being. One healthcare professional said "The registered manager always informs me of how residents are progressing. Bransfield Manor is an excellent home, treats its residents very well."

Requires improvement

Is the service caring?

Our findings

One person said, “I like it here.” A relative told us, “It’s marvellous. The staff are very good.” They said their relative had settled in well and they were quite happy with the place.

People were not consistently treated with dignity by staff. Although we observed some staff treated people with dignity, this was not consistently done. There were five people sitting in the lounge area. We undertook a SOFI (Short Observational Framework) and saw one person had sat for two hours with very little interaction from staff. Another person was asleep, a staff member tried to wake this person to give them a cup of tea. When the person still didn’t wake up staff put a bib on them whilst they were asleep andplaced a biscuit into their hand to wake them up.

One staff member was seen kneeling down talking to people as they gave them their tea and biscuits, we noted they handed out biscuits themselves, rather than letting people take or chose their own. People were spoken to generally in a neutral or negative manner; Such as “Are you alright?”, “How are we getting on then”, “You like tea don’t you?” Negative comments from staff included “Drink your tea, good girl” and “Drink your tea before it goes everywhere.”

During the observation we noted one staff member who was heard to ‘huff’ when one person said they didn’t want any more of their lunch. We saw that bibs were automatically put on some people at lunch or when they had their tea. We spoke with one member of staff about this and were told that “They are not put on to stop people’s clothes getting messy, but to stop them getting burnt if people spilt their tea as one person in particular had a shaky hand.” At lunchtime a trolley was bought into the dining area where the uneaten food was scraped off plates in the dining room in front of people. The TV was left on and loud and people stated they did not like the noise however staff did not do anything about this.

On another occasion we observed three staff members supporting someone to move using a full hoist as the stand aid hoist was broken. The person was distressed and shouting “I don’t want to, it’s hurting me”, “I want to go to sleep”, “I want to stay here in my chair”. As a result of their distress, another person became anxious and the third staff member-directed her away. There was very little communication or re-assurance from staff during this process. One staff member did not know which straps to use, and had to be prompted by another staff member which created further distress for the person.

The lack of consideration and respect to people is a breach of Regulation 10 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Peoples care plans had been reviewed regularly. Staff told us that they were in the process of updating them. We asked people and family members if they had been involved in their care or the care of their relative. Relatives said they were not always included and not kept up to date by the staff at the home. Two people stated they had not seen their care plans or been asked for their preferred choice in aspects of care. Staff told us that relatives visit and that the home has no limitations on visits. Care staff said that they support people to maintain close contact with their family.

Requires improvement

Is the service responsive?

Our findings

One person told us "It's quite boring here." And "I don't do a lot." Another person said "No one really talks to me now my friend has died." Staff did not always spend time with people in a social manner. We did not see many occasions when staff sat and interacted with people. Staff told us that they did not have time to sit with people.

People did not have access to activities that met their needs. One staff said there was no meaningful social interaction with people during the day, but they did have limited activity groups through the month such as keep fit, music and doing people's nails. They said activities weren't individualised. Another member of staff said they could do more to interact with people and were not sure why they didn't. The registered provider said they did not have a staff member solely employed to support people to undertake meaningful activities.

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. Staff did not support people to undertake individual social activities of their choice, or encourage people to have a fulfilling day. We saw people sitting in the lounge areas for the majority of the day. People were asleep from lack of stimulation. The TV was on however people told us they didn't know why it was on, who put it on and they weren't watching it.

One person told us "I just sit here all day, from when they get me up to when they put me to bed." Another person said "I'm bored to tears." People's care plan identified their hobbies and things they enjoyed doing such as listening to music, however staff did not support people in pursing these interests.

The environment lacked stimulation for people living with dementia and did not build on people's skills and talents. For example, labelling cupboards and drawers or using pictures and words. We observed several people in the home walking throughout the day looking for their rooms and for something to occupy their time.

Staff was given appropriate information to enable them to respond to people's needs. This included a one page pen profile of people, which included their health needs like, dislikes and preferences. Care plans had been reviewed regularly and provided clear direction for staff in what care to provide for a person. Care plans also contained information on people's medical history, mobility, communication, and essential care needs including: sleep routines, continence, care in the mornings, and care at night, diet and nutrition, mobility and socialisation. These plans provided staff with information so they could respond positively, and provide the person with the support they needed in the way they preferred.

However we did not see staff always following the guidance given in the care plans, for example; we observed one person who required the assistance of two carers to transfer from sitting to standing, the care staff were using incorrect techniques (both carers were bending and reaching down to her back, not sitting the person forward). The care staff did not interact with the person and talk to them about what they were trying to achieve.

On another occasion we saw one person calling out for support, staff supported them to stand by grabbing the person's trousers rather than using the manual handling belt as directed in the persons care plan. We noted that once the person had stood up they were wet. We pointed this out to the carers, who supported with personal care before lunch. We spoke to the care staff about this and told that the person had been sitting in the chair since they got up this morning at 6:30am. This meant that staff were not providing care and treatment appropriate to individual needs. We spoke to the registered provider about this and they said they would address the issue immediately with the staff.

Staff did not provide appropriate care to people as directed in their care plans or support people undertake meaning full activities. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. correspond

People's views had been obtained through feedback questionnaires. We saw people had requested more snacks be available, more activities be offered and the garden be made accessible. No follow up, action had been taken to address these requests. The registered manager said they were in the process of addressing the issues raised but some of the tasks came down to a "lack of staff."

The home had a complaints policy and procedure although this was not displayed to ensure people were aware of how to make a complaint if they were concerned about

Requires improvement

Is the service responsive?

something. We looked at the complaints records which showed us no formal complaints had been made within the past year. Relatives we spoke to confirmed they had not made any complaints.

Requires improvement

Is the service well-led?

Our findings

A relative said "It's well run." Staff said there were staff meetings and they felt the registered manager was supportive and approachable. One relative said "Happy with service, the registered manager and team have best interests at heart, team are experienced."

At the last inspection on 11 & 12 November 2014, we asked the provider to take action to make improvements to the quality assurance process used to ascertain quality within the home. At this inspection we found improvements had been made.

The registered manager had introduced a new quality assurance system. We saw evidence of audits for health and safety, care planning, medication and infection control. This enabled the manager to identify deficits in best practice and put actions in place to rectify these. The registered manager told us that they were working on actions identified in the Adult Social Care and Continuing Healthcare Quality Assurance Report from June 2015. This showed that the manager was continually assessing the quality of the home and driving improvements. We saw policies for Health & Safety which was dated November 2014 and included relevant information in the case of an emergency. A fire risk assessment had been carried out February 2015.

The registered manager explained that there were still actions to be addressed and they were working on these, such as recruiting staff and devising a meaningful activities programme for people. The provider was aware of the ongoing maintenance needed in the home and was looking at the costing of a refurbishment programme.

The registered manager said that monthly staff meetings were held. We saw copies of minutes of the meetings that showed best practice issues were discussed. Staff were positive about the management of Bransfield Manor. They told us they felt supported by management and could go to them if they had any concerns. One member of staff said it was a good group of staff who worked well together and there was good communication. They had staff meetings in which they could speak openly and make suggestions. For example discussions around the handover forms and on-line training.

One member of staff said when new staff started they received training on the aims and objectives of the service. It was then up to senior staff to monitor them to ensure they put these aims into practice. Any issues identified would be covered in an individual or group supervision session. This would develop consistent best practice and drive improvement.

People were not always given the opportunity to be involved in the running of the service. We asked for evidence of any residents meetings that had been held and we were not provided with these. Relatives said that they did feel involved but were not sure if residents meetings took place.

Staff said that the registered managers helped out and that they knew the people well and engaged with people. We saw examples of this during the visit. This showed us that manager was consistent, led by example and was available to staff for guidance and support. That they provided staff with constructive feedback and clear lines of accountability. They said colleagues were friendly and helpful with each other and they enjoyed working at the service.

We saw that most care records were securely stored maintaining confidentiality. The registered manager had ensured that appropriate and timely notifications had been submitted to CQC when required and that all care records were kept securely within the home.

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	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Staff were not providing care and treatment appropriate to individual needs. Or supporting people to undertake meaningful activities.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **People were not consistently treated with dignity by staff.**

Regulated activity	Regulation
	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The provider had not ensured that the premises were clean, suitable or maintained appropriately.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider did not ensure enough suitably qualified, competent, skilled and experienced staff was deployed to meet the needs of people.**