Foley House Trust

Foley House

Inspection report

115 High Garrett
Braintree
Essex
CM7 5NU
Tel: 01376 326652
Website: www.foleyhouse.org.uk

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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

The inspection took place on the 3 and 5 of June 2015. The inspection was unannounced on the first day and we arranged with the trustee to go back for the second day. At the last inspection of this home in January 2014 it was fully compliant. However since then both the Director of the company and the manager have left along with a number of senior staff.

The home provides support and accommodation for up to 21 people, the majority of whom have a sensory impairment. There is currently no registered manager and the day to day management is being provided by the trustees. 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. The home is being overseen by a board of trustees until a new manager can be appointed. The process for this has already commenced.

There were sufficient permanent staff at the home who were familiar with people's needs and able to provide

Summary of findings

them with appropriate support. However there were times when there were not enough staff to meet people's needs as thoroughly as staff would wish and the social opportunities for people were limited because of the availability of staff to support them.

Staff observed giving medicines did so competently. However there had been no recent medicine audits and we found some poor practices around medication practices which require improvement. We were not assured that people always received their medicines safely.

Risks to people's safety were assessed but records were not all up to date so we could not see how risks were effectively managed or how staff took into account a change in a person's needs..

Staff knew how to protect people from abuse and were able to tell us what actions they would take to keep people safe. Some staff training had lapsed and information was not readily available in the home to inform people using the service or their relatives how to report concerns.

Staff had not been effectively supported for their job role and training was not up to date. This was a key area for improvement and the trustees had identified what training needs staff had and were beginning to book training. New staff were being appropriately supported by more experienced staff and a formal induction process.

Staff supported people and asked for their consent before providing care and support. However staff had not received training in consent or capacity and may not be clear how to lawfully support people who lacked capacity.

People were offered a balanced diet but we could not see if people at risk of not eating or drinking enough for their needs were protected because staff were not regularly monitoring people's weights or monitoring people's fluid intake. Staff also lacked an in-depth understanding of specific health conditions.

People's health care needs were monitored and people had access to the relevant health care professionals.

Staff were kind and caring and promoted people's independence. However there was little evidence of how people were involved in the planning and running of the service or how their views influenced the service delivery.

People had a plan of care which helped staff know what people's needs were and how best to support people. Some records were not up to date so had not taken into account changing, or unmet need.

The complaints procedure was not visible within the main areas of the home and it was not clear how people would be supported to raise a complaint without being reliant on care staff to support them which might not be appropriate in all circumstances.

The home had undergone a number of changes which have threatened the stability of the home. There was no registered manager or staff able to fill senior positions after the sudden departure of a number of key staff. However in a short period of time the trustees had provided stability and were in day to day control of the home whilst they were in the process of recruiting a new manager. They were working hard to identify service shortfalls and put systems and processes in place which would underpin the service.

We found 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?
The service is not always safe.

People received medicines that were prescribed. Systems were not in place to monitor if people receive their medicines safety.

Staffing levels were not always adequate to people's needs.

Risks to people's safety were not always adequately planned for.

Requires improvement

Is the service effective?
The service is not always effective.

Staff did not have enough support or monitoring of their role to ensure they were working effectively.

People were supported with decision making but did not have staff who fully understood how to support people who lacked capacity.

People received a balanced diet but there was inadequate monitoring of people's weights.

Requires improvement

Is the service caring?
The service was not always caring.

People told us they were happy to be here. People were well cared for and supported by compassionate staff.

People were not adequately supported to make decisions or get appropriate support from outside advocacy services.

Requires improvement

Is the service responsive?
The service is not always responsive.

Staff responded to people's needs and generally people were well cared for but there was a lack of meaningful occupation for some people.

It was not clear how people were supported to raise concerns or give feedback about the service they received.

Requires improvement

Is the service well-led?
The service was not always well led.

The day to day management of the home was adequate and plans were in place to improve the overall service.

A lack of clinical oversight and poor day to day management of the service had compromised the service in the recent past.

Requires improvement

Foley House

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 3 and 5 June 2015 and was unannounced. The inspection team comprised of one inspector and an expert-by-experience on day one and two inspectors on day two. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case they had personal experience of sensory loss.

Before the inspection we contacted the Local Authority and requested some more information amidst concerns of the sudden departure of the management team. We reviewed information we already held about the service including previous inspection reports.

During the inspection we spoke with seven people using the service, observed the care and support provided to them. We spoke with two visiting health care professionals, one relative and eight staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We looked at four care plans, and records relating to the management and running of the business. We spoke with one of the trustees at length about the future management arrangements of the service.

Requires improvement

Is the service safe?

Our findings

Staff told us that at times staffing levels were reduced and staff had worked with just one other staff member. Staff said at times there were not enough staff and staff expressed concern about the level of inactivity for some people using the service.

The home had recently undergone a number of changes with the departure of the Director, manager and a number of long standing staff. This has resulted in a number of staffing vacancies which has impacted on the service. The trustees had also reduced the number of agency staff in order to control costs which had further increased the pressure on existing staff. On the day of our inspection one of the trustees was in day to day control and there were arrangements in place to ensure that there was appropriate management arrangements in place at all times and staff said they felt supported.

We were unable to see how the trustees determined how many staff they needed based on people's dependency levels. The trustee said they had guidance around staffing levels and were assessing people's needs to ensure they could provide the right level of staffing. They said they had filled recent vacancies and did not need to use agency staff any more. They were shortlisting for the manager's position and hoped to interview the following week. They said they had bank staff and a volunteer working at the home.

We noted during the inspection that one person required support from two members of staff due to the nature of their illness, others required full hoisting. The home was not full but a number of people had recently moved to the service for short term care and the needs of people outweighed the availability of staffing. For example two staff told us when there had not been enough staff given that some people needed a lot of support and one person needed two to one staffing at all times. Staff told us they were able to meet people's needs but not able to give them the time and attention they needed or able to keep up with additional responsibilities which would have previously been fulfilled by the manager and seniors who had left. We raised our concerns with the trustee about only two members of staff being on duty. They told us this was a thing of the past and there were additional staff supporting care staff including apprentices. There was administrative, domestic, management and catering support. There was also a person supporting activities which was not included in the available 'care hours.'

People reported being under stimulated with not enough to do to keep them occupied and stimulated. Some people were unable to get out independently and there was not a robust plan in place to meet people's social needs. There was a person responsible for overseeing activities but they were part time which was insufficient and led us to believe there were not always enough staff to meet people's needs.

This was a breach of Regulation 18: (1) HSCA 2008 (Regulated Activities) Regulations 2010 Person: Staffing

We could not see how risks to people's safety were always effectively managed. We viewed people's records and found their documentation was not up to date and did not always take into account a change of need or risk to the person. For example we found one person needing support with their mobility to stay safe. They did not have a manual handling plan or falls risk assessment in place despite a number of recent falls. Diabetic care plans were not in place and there was no short term care plans in place. This might be appropriate when a person had an infection and prescribed antibiotics. This could affect the persons overall well-being and mobility but staff might be unaware of this as it was not recorded in their daily notes or plan of care.

We saw for another person that a change in their medicines made them unsteady and at increased risk of falls. This was documented but there was no risk management plan or clear guidance for staff of how this risk should be managed or reduced. The person was also at risk from malnutrition/ dehydration. Although this was a known risk as identified in their care plan it was not clear from their records how this was being effectively monitored. They were not being weighed regularly, their nutritional plan was not up to date and there was no recording of their fluids outside of meal times, or evaluation of this data to see if they were eating or drinking enough. We saw their current diet was restrictive and might not be sufficiently balanced.

Risks to people's safety were increased by poor medication practices. Medicine records showed us what people were prescribed. A lot of medicines were prescribed on an as required basis such as analgesics. However on the medication record some people had been on these medicines for a long time and it was not clear if this had

Is the service safe?

been reviewed or if people actually continued to need these medicines. There was no guidance for staff as to when PRN medicines might be appropriate and when they should be administered. This could lead to overuse or inappropriate use of medicines. For example one person had been prescribed medicines to help manage their anxiety. Their care plan did not give details of when this drug should be used and when it might be most effective or what other approaches staff could use to minimise this person's distress.

We noted that people had purchased their own analgesics and these were being purchased alongside other prescribed medicines. They had not been authorised by a GP and we do not know if they might interact negatively with medicines already prescribed. Some people were taking large amounts of medicines. We could not see when people last had a medicines review.

The homes medication was administered by only a small number of staff who told us they had been appropriately trained and assessed. However we were unable to verify this on the day of our inspection because records were not available. Staff were knowledgeable about what they were doing but told us another member of staff who was not on duty did all the ordering/audits of medicines so it was unclear what would happen if they were sick or unable to continue their duties.

We looked at medicines and found generally there were no gaps in staff signatures and the number of tablets in stock tallied with the records. On the medication record there was the person's name and picture to help staff ensure they had the right person. However we saw no details of any allergies recorded or any considerations about how the person took their medicines. One person found it difficult to take their medicines and the GP had said about completing a mental capacity assessment and making a best interest decision to administer medicines covertly. This was not in place.

We were unable to see what systems were in place to ensure medicines were administered safety, correctly stored and remained appropriate to people's needs. Stock taking was done monthly but there was no system to monitor records and check people's medicines tallied at more frequent intervals. Having fed-back our concerns to the trustee they showed us the audits they had devised which included daily, weekly and monthly audits and how a number of staff would be responsible for medicines and assessing and supporting other staff to ensure they had the right competencies to administer medicines safely. They also agreed to contact the external pharmaceutical company to ask them for their support and for them to carry out external audits.

This was a breach of Regulation 12: (2) (a) (b) (f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People's records showed us that staff were reporting and recording events affecting the well- being and safety of people using the service such as falls and in one instance a medicines error. Records showed us what actions staff had taken to promote the person's well-being and safety but we were unable to see what actions had been taken to help staff improve their practice. In the absence of regular staff supervision, training or appraisal of staff performance. There was no system to centrally record events affecting people's well-being and, or safety but this was being developed.

Staff spoken with had received training in safeguarding but some had not done this recently. There were insufficient records to support if this training was up to date or not. However staff felt confident with the current management of the service and felt able to report concerns and felt they would be acted upon. They were aware of external agencies and how to escalate concerns if necessary to protect people at the home.

Staff had access to safeguarding and whistle- blowing policies which meant they had the information they needed to raise concerns. Some staff told us they had raised concerns and these had been listened too and addressed. Other staff said they would not hesitate to raise concerns if they had any. We saw concerns had been raised about one person and this had been reported, to the safeguarding team and an investigation was underway. We saw that very detailed notes were being recorded to safeguard the person and members of staff providing their support. i

Staff recruitment was on-going. Gaps in staff files had lead the trustee to complete an audit of what was available for each member of staff to identify the gaps so this could be addressed. We did not examine any staff files of staff who

Requires improvement

Is the service safe?

had been there some time. We did however look at new staff records and found these were in systematic order with evidence of pre requisite checks in place to demonstrate the suitability of staff for their current position.

Requires improvement

Is the service effective?

Our findings

Staff spoken with were familiar with their roles and newer staff said they were well supported by existing staff. All staff expressed confidence in the current management arrangements and felt things were moving in the right direction. The organisational structure had been affected since the manager and a number of senior staff had left leaving a number of senior staff vacancies and currently no staff who were able to take on these specific areas of responsibility. This was still being resolved. The trustees were in day to day control of the home and had begun to delegate tasks and support existing seniors in their role. There was usually a trustee and a senior on each shift and adequate on call arrangements.

The trustee told us that staff had received supervisions in the past but the supervisors had since left. Staff told us supervision had not been carried out frequently and was often done in response to a concern rather than planned throughout the year. The trustees said they were in the process of carrying out annual appraisals for each member of staff to identify where their strengths were and where they needed support including any specific training. Once they had done this they could establish specific roles for staff members and support more senior staff in their role in developing and supporting junior staff. They were also hoping to have a manager in place shorty and the annual appraisal would help the manager know what the skills of their work force were and where the gaps were.

New staff were completing a three day work based induction in which they were introduced to the service and underpinning policies and procedures. In this time they were shadowed by more experienced staff. Throughout their probationary period they were working through an induction booklet and completing some training to ensure they had the necessary skills and competencies. Before staff could do certain things such as manual handling they were shadowed until they had completed the training.

Staff records were not in systematic order which made it difficult to see how often staff had received formal support from the manager or how their competence had been assessed. Training certificates were not always in staff records. Staff told us about the training they had received but we were unable to see if the training had been refreshed at regular intervals or how staff kept up with best practice. Some staff had not completed some essential training since first starting their job.

The trustees were unclear as to what the staff training needs were and had started to collate information on a spread sheet. This showed what training staff had done and when it should have been refreshed. The trustees said they were renewing all staffs training. Some training such as first aid had been prioritised and was booked for the following week. Other training was being planned and we will ask the trustees for an update.

Some staff did not have the necessary skills to meet the needs of people using the service. For example a number of people had early onset dementia and issues with mental health. Not all staff had received dementia training. Some staff were not familiar with British sign language used by about 80% of people using the service. This meant staff did not have the right skills and competence and there were no systems in place to effectively support staff and identify their training needs.

This was a breach of regulation 18(1) (18(2)(a)

Staff had not had training on the MCA or DOLS. However in practice we saw staff supporting people appropriately and providing care in the least restrictive way and offering people choices in relation to their care and welfare.

Care plans did not contain an assessment of people's ability to make day to day decisions or how they could be supported to make decisions. We saw some examples of where people were deemed to lack capacity to make decisions about certain elements of care and decisions had been made on their behalf without a record of how this had been done in their best interest and involving interested parties. Such as do not resuscitate forms in place which had been instigated from the hospital without any consultation with next of kin. Another person was not always compliant with their medicines and the GP had recommended staff complete a Mental capacity assessment to assess this and suggested covert administration of the persons medicine might be in their best interest. This had not been addressed by staff. Some people were unable to leave the home independently so

Requires improvement

Is the service effective?

were restricted for their own safety but no Deprivation of Liberty safeguards application had been made to the Local Authority to assess this and ensure any restriction was lawful.

This was a breach of regulation This was a breach of Regulation 11 (1) (2): (1) HSCA 2008 (Regulated Activities) Regulations 2010 Person: consent.

People received a balanced diet. One relative told us the food was wholesome and well cooked with no ready meals. One of the people using the service said, "The food is sometimes good, sometimes bad. You can have an alternative if you don't like the choice. Curry yesterday was nice and the lasagne the day before was quite nice." We observed the lunch time on two separate occasions and people were supported appropriately. We did not see any menus displayed but staff told us people were offered a choice of at least two main options and various options, including a cooked option for breakfast. People were asked if they wanted sauce on their fish and were given a choice of vegetables. We observed no food waste.

People were observed to have a variety of drinks in front of them. However we were unable to see from people records how people identified at increased risk of malnutrition or dehydration were closely monitored. There were care plans in place but no risk assessments. People's weight records showed they were not being weighed regularly and where people had nutritional screening tools in place because staff were not able to weight them these were not kept up to date. Only one person had regular nutritional supplements but without up to date information on people's weights it was difficult to see who was at risk. Staff kept a record of what people were eating and drinking but only in relation to meal times and there was no analysis of this to see if it was appropriate. One person was eating a very restrictive diet and it was not recorded what staff were offering to them and if snacks were regularly available.

The trustee had formulated a nutritionally balanced menu on a four week cycle which took into account people's preferences. However we were unable to see how people inputted into their food choices or menu design.

Staff had not had training on how to support people with diabetes or recognise when their condition might not be well managed. There was no diabetic care plans in place and although people were regularly seen by the district nurse's staff might be unaware of when to refer the person to a specialist. Staffs knowledge on diabetes was limited. Staff had not been trained on using a malnutrition universal screening tool (MUST) which was a tool used to measure someone's weight through measurements if they could no longer use scales. This meant MUST forms were unreliable as staff had not been trained how to complete these correctly.

This is a breach of 14, (1) Meeting nutrition and hydration needs.

A relative told us their family member had access to health care and was regularly visited by a GP and other visiting professionals. They chose to go out to the dentist. They said staff kept them up to date with any changes in their needs and updates to their medicines.

People's health care needs were recorded and health care professionals contacted as required with good access to the GP surgery and the district nurses. It was not always clear how often other services such as the dentist were accessed. Because records were not kept under frequent review we could not always see how something had been followed up. For example where people had refused an aspect of the treatment or required some follow up. One example was a person had a concern flagged up as part of a blood test but we do not know what happened as a result of this. We therefore could not be assured this persons health care needs were being met or any risk had been eliminated.

Requires improvement

Is the service caring?

Our findings

One relative told us about the care provided to their family member. They said it was very good and their needs were met Their relative was in hospital. They told us, “Mum can’t wait to get back here.”

Most staff were familiar with people and on the day of inspection provided unrushed, timely support. Changes in the staff team had meant some of the more senior staff had recently left. However the core team of staff were very experienced and were clear that their priority was to the people who used the service and told us people’s needs were currently being met and they felt confident with the interim management arrangements.

Through our observations of people being supported we noted positive interaction with staff sitting with people and joining them for lunch. Staff used good eye contact and responded appropriately to any request in a friendly manner. Staff were observed encouraging people and ascertaining if people were alright and had everything they needed.

Most people using the service had a sensory impairment and used British sigh language. Not all the staff were sufficiently trained to use British Sigh Language fluently and were reliant on people using the service to teach them. However there were things in place to help staff master sign language such as e-learning. One person expressed concern about a new member of staff. This was because the staff member was not able to communicate effectively with the person they were supporting.

A lot of changes had occurred in the home and it was not clear how much information had been given to people using the service about these changes. We asked the trustee if people had advocates who could ‘speak up’ on their behalf. An example of when this might be beneficial is if a person wanted to make a complaint against a staff member. Currently people relied on staff supporting them to help them raise concerns which might not be appropriate in some circumstances.

A relative told us they had been advised that the manager had left and what the interim management arrangement were. They said they had received a letter from the service. They said that they had not always been kept informed by previous management as to how their concerns had been addressed. We asked the trustee and staff if resident/ relative meetings were held and were told this was not something that had been happening. The trustee said they spoke with staff, and people that used the service daily and involved themselves in the staff handovers to ensure they knew what was going on. They said that people’s needs were to be reviewed at least once a month and this was going to be done in conjunction with staff that knew the person best, the person themselves and any- one involved in the person’s life. This would provide the opportunity for people to be more involved in the planning and reviewing of their care. There was little evidence that this had happened previously.

We saw in practice staff consulted with people about what they would like to do and gave people choices on when they wished to get up, what they wished to do and what they wished to eat. The home employed a person to support people with social activities and some people had regular things they did whilst others did not.

We observed respectful practice and saw people’s independence and dignity was promoted. For example at lunch time we saw that people had all the equipment they needed to be able to eat independently. People told us about the things they did during the day and said they could get up and the time of their choosing. We observed staff supporting people with their mobility and where people needed assistance to go to the toilet this was offered discreetly. Staff offered appropriate support and did this sensitively and discreetly. We observed people doing what they could for themselves and contributing to the smooth running of the service.

It was not clear from people’s care plans how people would be supported if they needed palliative care. The trustee said they would be guided by other professionals and put into place a preferred priorities of care to ensure they could appropriately support the person and in accordance with their wishes. Most staff had not received training in palliative care and the two staff that had had not undertaken this recently.

Requires improvement

Is the service responsive?

Our findings

We received mixed feedback from people in relation to how the service provided activities that met their wishes. One person told us they were going to the local carnival tomorrow and said they went to various other places giving us their thumbs up to say they enjoyed what they did. However another person said, "I get very frustrated, I want to do what I want to do. I have no social life I can't talk to people."

A relative told us how the care provided was centred around their family's needs. They said for example staff brought their family member a cup of tea and let them wake up in their own time before assisting them with their personal care. This was echoed by staff who were able to describe people's individual needs, preferred routines and interests. Despite the inspection activity we observed staff providing care and support in an appropriate, timely way and did so in a relaxed pace. Staff told us the only time this was compromised was when they were short of staff which they said happened occasionally and gave us an example. They said this impacted on time they had to spend with people.

We observed people pursuing their own interests and hobbies but several people told us they felt bored and under stimulated in the home. This was evidenced further by the lack of forward planning for activities. Some things were happening in the service and some people had regular activities they attended but this was not the case for everyone. The trustees were not clear about each person's daily routine and the activities taking place. This was something they wished to develop to ensure people received sufficient stimulation. We also noted that people helped in the home and some laid, cleared tables and more able people supported those less able and undertaking some of the domestic routines.

There was a person providing activities who worked on a part time basis but they were not there on the day of our inspection. Staff told us they took people out. Staff said the minibus was currently broken but they had recently recruited a part time driver. They said they used taxis and took people shopping and to the library.

There was no information for people using the service or visitors to the service on how to raise concerns or who they should refer to if they felt unsafe. People relied on staff to support them and there was little in terms of external support or details of other organisations who could advocate for people if required. This could leave people vulnerable.

People's records told us about the person's main needs and how they should be met. Staff recorded daily on how the person had been, any concerns and what they had eaten. Where there were concerns about people then records were kept more frequently and there were regular staff handovers to ensure all staff were familiar with any changes to people's needs.

Staff were able to tell us about people's needs but were not clear who was responsible for keeping care plans up to date. This had lapsed within the home and we found some records had not been reviewed for two months or when there had been a change of need. The risks to people's safety had not always been clearly assessed, reviewed or actions considered following a fall. We fed this back to the trustee who was very clear that going forward all care plans would be reviewed monthly with a system of one care plan being reviewed each day which would mean by the end of the month they would all be reviewed. They said this had already started so some care plans were up to date and checked by the trustees to ensure they were accurate.

There was some monitoring of people's mental health but we saw a description of people's behaviour rather than any analysis of it and we could see no strategies in place for staff to follow to try and minimise unwanted behaviours or minimise people's distress. There was some mental health specialist input but the home had not considered peoples routines and levels of activity as a possible contributory factors to people's well-being or ill being.

This was a breach of Regulation 9a 1) (a) (b) (c) (3) HSCA 2008 (Regulated Activities) Regulations 2010 Person centred care.

We were unable to see the complaints procedure displayed in the home. We were told there had not been any complaints about the service but felt people might not know how to complain and could not without staff support .People were given a service user guide which included how to complain but staff told us at least one person was unable to read.

Requires improvement

Is the service well-led?

Our findings

There had been a lack of clinical oversight and clear leadership at the home. Staff reported concerns about the way the home had been managed and felt that they were not supported appropriately in the past. The trustees had not concerned themselves with the day to day running of the home and had left that to staff who had been employed to do that. Things had started to break down and a number of senior staff including the registered manager had left. The trustees had stepped in to oversee the day to day running of the home and this was still a new arrangement.

Staff told us the trustees were getting to grips with the issues and beginning to turn the home round. They said that they felt confident with the management of the home. We identified a lack of clarification of who does what at the home. For example one senior was responsible for everything to do with medication. In their absence other staff were not clear about the processes. This was being rectified by the trustees who were becoming familiar with the processes and the senior was working with other staff so they too became familiar with the processes. Roles and responsibilities were being sorted out but the trustees needed to know the strengths of each individual team member before this was agreed. They were doing this by spending time with staff, observing their practice and carrying out staff appraisals. They would then be in a better position to know how best to utilise their skills.

It was difficult to establish how people using the service felt about recent changes as there was no documentation in the home and it was not clear that people had been adequately supported or consulted about the situation. We were advised that people's needs would be reviewed to ensure they were being met with the service. Some people told us of their frustration of not being able to do enough of what they wanted and concerns about changes in the staff team and staff that were not familiar with their needs.

Staff had a good working knowledge of the home and said they were able to meet people's needs but needed more training on specific needs which they said they had already been asked about so they knew more training was coming.

Staff reported a positive working atmosphere and good team work; although we were aware some staff were working up to sixty hours before a day off so were tired. Staffing vacancies had been filled.

Staff told us if they had concerns about the home and people's safety they were aware of agencies to contact externally if required. Staff all felt the trustees were approachable and available in all circumstances. The out of hours was covered by seniors and trustees and staff said it worked well. Any shortage on shift was reported to the trustee who could then respond and support staff.

One staff member told us, "They are a brilliant team. The care is never compromised."

The trustees were systematically going through what was required to bring this service back in line and were developing systems and processes to support the service delivery. For example policies had been revised and used as the basis to develop good practice. Staff files had been systematically sorted to see what was in place and where the gaps were and centralised computer records were being developed to give an overview of this. The trustees had responded to the Local authority by the way of an action plan and were keen to address current concerns.

There was documentation to record events affecting the well-being and, or safety of people living at the home and this was currently filed on people's individual records. The trustee said they were aware of issues and would report any concerns accordingly to the appropriate authorities. There was no central database to capture information of this nature but this was being developed.

There were poorly established links with other services and community groups but this was being explored to see how this could be advantageous for people living at the home and the plan was to do some active fundraising to support the on-going plans to get people more involved in the community.

The trustees showed us the last quality assurance review which was dated 2014. This involved asking people and their relatives how they viewed the home and if they were happy with the service. This had not been repeated since the changes but the trustees were aware of the institute of quality assurance and standards they should be achieving

Requires improvement

Is the service well-led?

in their industry. We have arranged to meet with the trustees following the issue of the draft report to see what actions they had taken to engage and consult with people using the service and plan to improve the service.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment The service had not ensured that risk assessments relating to the health, safety and welfare of people using the service were in place and where they were kept up to date. There was not always a plan in place showing how risks were managed. Medicines were not always managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The service had not ensured that the care and treatment of service users was appropriate to their needs because they had not kept people's needs under regular review or ensured the plan of care reflected the persons current needs and any risks to their safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service had not deployed suitably qualified, competent, skilled and experienced staff to meet people's care and treatment needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The service had not assessed people's nutritional or hydration risk and were not able to demonstrate what steps they had taken to monitor and, or reduce the risk to people.
	The service had not ensured that people's consent had been sought or where they lacked capacity to give consent that staff acted in accordance with the Mental Capacity Act 2005.