Downing (Barwell) Limited

Saffron House

Inspection report

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27 June 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this service on 23 and 27 June 2016. The first day of the inspection was unannounced.

Saffron house is a 48 bedded residential home for older people, some of whom have dementia. On the day of our inspection there were 39 people using the service.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were left in communal areas for long periods of time without the support they required. There were not enough staff to keep people safe and to meet their needs. People were at increased risk of falls or harm from other people who used the service due to behaviour that may challenge others.

People were not sufficiently protected from the risk of harm or abuse. We saw that staff had not recognised when people's behaviour towards others may have been abusive and had not reported it to the appropriate authorities.

People were supported to take their medications as prescribed by their doctor. Systems to ensure that medicines were stored, recorded and administered safely were in place. However people could not always be sure that their skin would be maintained safely.

Risk associated with the environment and equipment used had been assessed to identify hazards, and measures were in place to prevent harm. Records of these checks were however not readily available for the provider to refer to..

People could not be sure that they received care from staff who had the knowledge and skills to carry out their roles and responsibilities. Staff had not received regular training and support to enable them fulfil do their roles. Staff did not feel supported.

Nutritious Meals were provided and where people had dietary requirements, these were met.
Systems were in place to monitor the health and wellbeing of people who used the service. People's health needs were met and when necessary, outside health professionals were contacted for support.

The requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) were not met. Decisions were not made in people's best interest in line with the Act. Staff were not clear on their role and how to lawfully meet the requirements of DoLS

People told us that staff treated them with kindness but that they did not always give them the time that

they needed. People were not always supported to maintain their appearance to the standard that they would like. People told us that staff respected their privacy and dignity but that they did not always feel that their bedrooms were respected as their own.

People's care plans included information that guided staff on the activities and level of support people required for each task in their daily routine. People's needs were not always adequately assessed to ensure that the service could meet their care needs.

People were not always supported to engage in activities that were meaningful and of interest to them. We did observe some activities taking place during our inspection such as a ball game and singing. However we also observed periods of time when people in the lounges were provided with no stimulation or interaction

People's views were not always asked and acted upon. We saw that complaints had not been recorded and addressed by the registered manager.

The registered manager had not informed CQC of significant events that happened in the home. We identified occasions when we had not been made aware of safeguarding events.

The registered manager had failed to ensure that robust records and data management systems were in place. Effective systems were not in place to monitor the quality of the service being provided.

Staff did not have faith in the registered manager and did not feel supported. The regional manager was overseeing the service. They told us that this was in order to monitor the activities that were taking place, support the registered manager and to support the staff team in the implementation of new care planning documentation.

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

There were not enough staff to keep people safe. People were not protected from the risk of harm or abuse. People received their medicines as prescribed by their doctor but creams were not recorded as having been administered. Risk associated with the environment and equipment had been assessed.

Is the service effective?

Requires Improvement

The service was not consistently effective

Staff had not received training and support to meet the needs of the people who used the service. People were supported to maintain their health. Their nutritional and hydration needs were assessed and met. The service was not meeting the requirements of the MCA.

Is the service caring?

Requires Improvement

The service was not consistently caring

People told us that staff treated them with kindness but that they did not always give them the time that they needed. Staff respected people's privacy and dignity but that they did not always feel that their bedrooms were respected as their own.

Is the service responsive?

Requires Improvement

The service was not consistently responsive

People's care plans contained information about the care and support that they required. People were not always supported to engage in activities that were meaningful and of interest. People's views were not always asked and acted upon

Is the service well-led?

Requires Improvement

The service was not consistently well led

Effective systems were not in place to monitor the quality of the

service being provided. The staff team did not feel supported by the registered manager. The registered manager had not informed CQC of significant events that happen in the home.

Saffron 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.'

We conducted an inspection on 23 and 27 June 2016. The first day of the inspection was unannounced.

The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. We spoke with five people and four relatives of people who used the service.

We looked at the care plans and care records of four people who used the service at the time of our inspection. During our inspection we spoke with staff members employed by the service including the cook, kitchen assistant, the person who oversaw maintenance of the premises, six care workers, the area manager, deputy manager and the registered manager. We looked at three staff recruitment files to see how the provider recruited and appointed staff. We also looked at records associated with the provider's monitoring of the quality of the service and evidence of staff training.

We observed care and support being provided in the communal areas of the service. This was so that we could understand people's experiences. By observing the care received, we could determine whether or not they were comfortable with the support they were provided with. We also 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.

Before the inspection we reviewed notifications that we had received from the provider. A notification is information about important events which the service is required to send us by law. We contacted health and social care professionals who have dealings with the service to gain their views of how the service was run and the quality of the care and support provided by the service. We contacted the local authority who had funding responsibility for some of the people who used the service.

Requires Improvement

Is the service safe?

Our findings

People told us that there were not enough staff to meet their needs. One person told us, "There are never enough staff but they do listen when you ask for something." A relative told us, "They need more staff." The relative told us that they, "Come daily to make sure things get done like mums nails, hair, showers to keep her clean and take some pressure off staff." We asked people if staff responded to their calls for support via the nurse call system. One person told us, "Not always, they can't because they are looking after others. You could wait about 20 minutes" A relative confirmed this, they told us, "We are kept waiting for ages, they don't respond to the call bell." Staff members confirmed this, they told us, "We have been under-staffed for months." Another said, "We're short-staffed today. There should be four and there's three". Other comments included, "There's not enough. The families tell us. We're lucky if we have three on each floor". "It's very stressful; people with high dependency needs need two carers. The turning takes so much time. People are not always getting a bath because of it". Another staff member confirmed this. They told us, "We can't do as many baths as we should." We reviewed peoples care records and found that two people had not received a bath within the past week.

We saw that people had risk assessments in place that stated that staff should observe them at all times to help reduce these risks. We observed how people who used the service were supported by staff and found that there were times when people were left unsupported in communal areas for up to 15 minutes. Staff were supporting people in other rooms. This meant that people were at increased risk of falls or behaviour that challenged from other people who used the service. This meant that people were not protected from risk of harm. We asked the registered manager about staffing. They told us that they assessed people's dependencies on a monthly basis and were actively recruiting new staff. They told us that they were not aware that staffing levels were not suitable to meet people's needs, however staff members and a visiting health professional told us that they had raised staffing levels as a concern in the past.

These matters constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from harm and abuse. We saw records that showed that appropriate action had not been taken when abusive incidents between people who used the service had occurred and continued. One staff member told us, "There has been an incident and it wasn't handled well. Something was reported from a carer to the senior and then the manager and he failed to inform the family. They were very unhappy". We saw that staff had not recognised when people's behaviour towards others may have been a form of abuse and had not reported it to the appropriate authorities. This included potential sexual abuse. This denied people the protection that referrals would have offered. We saw that people's support plans and risk assessments had not been reviewed and actions taken to prevent further occurrences. The registered manager was not aware of incidents that had occurred and therefore had not reported them to the appropriate authorities.

These matters constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a recruitment policy in place which the registered manager followed. This ensured that all relevant checks had been carried out on staff members prior to them starting work. We looked at three recruitment files. We found that all the required pre-employment checks had been carried out before staff commenced work. These records included evidence of good conduct from previous employers, and a Disclosure and Barring Service (DBS) Check. The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff who may be unsuitable to work with people who used care services. This meant that safe recruitment practices were being followed.

We received mixed views about the cleanliness of the home and how it was maintained. One person said, "Sometimes the hygiene isn't what it should be." A relative told us, "The hygiene is terrible," and "The whole place smells of wee." Some areas of the service were malodorous during our inspection. We saw that the domestic staff were working during the time of our visit and rotas were in place to help ensure that each area received the attention of the domestic staff. We spoke with the area manager about this who told us that furniture and flooring had been replaced to try and combat this. During our inspection we saw that further flooring was being replaced. Our observations of the environment were that it appeared to be clean, tidy and free from clutter. However we noted a pressure cushion that was visibly dirty and sticky to the touch.

The home was generally very warm on the day of our inspection. Three people told us they were hot and looked so. Fans were in operation in only two staff offices although the registered manager told us these were available for other areas. Staff had not taken action to relieve people's discomfort. We asked the registered manager to ensure that the temperature of rooms were monitored and a heat wave policy implemented. After the inspection they told us that they had taken appropriate actions to ensure that people were protected from the risks of high environmental temperatures especially during the summer months.

People told us that they felt safe when staff supported them with their mobility. One person said, "I feel safe when they hoist me." However we reviewed accident forms that showed that accidents and incidents had occurred during moving and handling. Some of these were currently being investigated by the local safeguarding authority. We observed two people being supported to move with a hoist. Staff did this carefully, spoke to the people gently, told them what was happening, and gained consent. Not all staff had received the appropriate training to enable them to safely support people with their movement.

We reviewed people's plans of care and found risk assessments had been completed on areas such as moving and handling, nutrition and skin care. These assessments enabled staff to identify risks to people's care and provided the guidance for staff on how to minimise the impact of these risks. People's risk assessments had been reviewed regularly however had not always taken in to account events that may have meant that the support they required had changed.

People could be assured that they received their medicines as prescribed by their doctor. Medicines were all stored securely. Staff had identified that the medication refrigerator temperature was too high at times. We saw that action had been taken to address this. We saw that medication administration record (MAR) charts were used to inform staff which medicine was required and this was then used to check and dispense the medicines. We saw that a stock check of medicines was taken regularly. We observed staff administering medicines. Once a person had taken the medicine the MAR chart was then signed. Staff had received appropriate training and competency checks before they were able to administer medicines to people. However staff annual competency checks were overdue.

Staff understood how people liked to receive their medicines and offered them choice and information. One staff member told us "[person's name] likes her medication with squash, she doesn't like it with water." There were medication profiles which informed staff of how each person liked to receive their medication and aid consistency in administration. Where people had PRN [as required] medicines there were protocols in place to guide staff. We saw that the appropriate authorisations had been granted for a person who needed to receive their medication covertly.

Where people required creams to help maintain healthy skin these were not recorded. We were told that a system for recording had been in place but that it has recently been removed. We reviewed the old records and found that there were gaps in the recording. This meant that staff could not be sure if prescribed creams had been applied or not.

Risk associated with the environment and equipment used had been assessed to identify hazards and measures had been in place to prevent harm. Where regular testing was required to prevent risk, such as water temperature testing and weekly fire equipment checks we were told that these took place but records were not available on the day of our inspection. We saw that other equipment checks were in place to ensure that it was safe for people to use, for example hoists. The was a fire risk assessment in place and the support that people would need to evacuate in case of fire had been assessed.

Requires Improvement

Is the service effective?

Our findings

Staff did not always have the knowledge and skills to meet people's needs. One person told us, "They are not trained enough." We were told that only two staff had received training around a person's specific health needs. Another staff member told us, "We're not getting training as a result [of staffing issues] ".Staff told us that they had not received training when they started working at the service that enabled them to understand and meet people's needs. One staff member said, "I didn't have an induction just a walk around". New staff were required to complete induction workbooks to show their learning however these had not been completed. We brought this to the regional manager's attention who told us that they would ensure that induction booklets were completed and staff members who had not been trained in moving and handling be taken off the rota until they were trained.

Staff had not completed relevant training such as manual handling and health and safety training. They confirmed that they had been required to support people with their mobility without the required training. The registered manager had not established if staff had the required qualifications to complete their role. For example a member of staff who worked in the kitchen had not provided the registered manager with an in date food hygiene certificate. One relative told us, "We were told before [relative] was admitted that they could manage her [specific care related need] but no-one is trained to deal with it." We confirmed that only two staff members had received training regarding how to support the need. When the service employed staff from an agency they had not ensured that these staff were suitably trained and qualified for the role. Agency staff did not receive formal inductions to the service. We were given a list of training that staff had completed however some staff told us that they had not completed some of the courses. We asked to see the certificates but these were not available. The regional manager told us that staff had completed the courses on a one to one basis with the registered manager but that they had not yet printed the certificates.

Staff did not receive effective supervision to support them to understand their roles and responsibilities. One staff member said, "They're sporadic. Not helpful as nothing is ever followed-up" However another staff member told us, "We have appraisals and supervisions. The last one was six months ago. They are useful when they happen". We reviewed a supervision matrix that indicated that most staff had received a supervision in January 2016 and around half of the staff had received a supervision in April 2016. We checked staff supervision records and found that they lacked detail regarding the support and practice of staff. We brought this to the registered manager's attention who said that they would review the content and how supervisions were recorded.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Act. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

We saw that there was reference to people's ability to make decisions in their care plans. Where people did not have the capacity to make decisions, best interest decisions had not been made on their behalf in line with the requirements of the MCA. Not all staff were not able to demonstrate an understanding of the MCA. One staff member told us, "I don't know a lot about it. We've not had the training on it." We were told that further training on MCA had been booked for all staff. The registered manager told us that they had applied to DoLS for people for whose liberty was being deprived. The record of the content of these applications had not been stored. This meant that staff could not be clear what deprivations were being requested to be authorised. For example we saw that one person was supported to sit in a chair that she could not independently get out of. Staff told us that this was to prevent her from slipping out of it. The provider could not be sure that this restriction had been recognised as a form of restraint and that authorisation had been requested. There was a risk therefore that people could be deprived of their rights without the necessary safeguards being applied.

We received mixed views about the food that was on offer. One person told us, "I can have drinks whenever I want but I don't eat much as I am waiting for new dentures. I am the last room on the corridor and my food is always cold and there really isn't much variety at teatimes." Another person said, "The food is fifty- fifty. There is usually a choice of pudding. I eat in my room, so the service could be better." Another person told us, "The food is good, with a choice of meals and something else if you don't want that." We observed that people had access to drinks throughout our visit. One person told us, "You get drinks all day long." We spoke with kitchen staff who confirmed that people were offered choices daily about what they would like to eat but that there was also the facility for them to prepare an alternative if people requested it.

During meal times we observed that some residents were served in the dining room, some in their rooms and some at lap tables in the sitting room. The food was well presented, well balanced and served in appropriate portions. Condiments were available to people and people were offered clothing protectors if they wished. People were offered a choice of what they would like to eat. Some people required support while eating and we observed that this was generally done at a pace that suited them however we observed other times when people required greater assistance than they received. We observe one person who had been served his meal while he was asleep and this was left in front of him for at least 20 minutes before he was prompted to wake up and eat it. The meal would have been cold by the time he did so. We also observed a person who struggled to cut up their food and transfer it to their mouths be given minimal support to do so and as a result they did not finish their meal.

Staff kept records of how much people ate or drank. Food and fluid charts were completed but the amount that people had drunk was not always totalled and there was no guidance for staff as to how much people should have to drink. The registered manager told us that they would monitor how people's fluid intake was recorded to help staff recognise if people had not drank enough.
There were monthly weight audits carried out. This was to identify if people had lost weight and make referrals to the GP or dietician in good time. We saw that these had been completed regularly and the appropriate referrals had been made.

People were supported to maintain their health. One relative told us, "There has never been a problem getting a GP or optician to see [relative]." A visiting health care professional told us that staff contact them in a timely way when they become concerned about people's health. They told us that staff seemed to understand people's health needs well. Records reflected this.

Where people required support to maintain their skin we saw that this had been provided. People's needs had been assessed and staff had completed the appropriate tasks to ensure that their skin remained healthy. We were made aware that the local district nurse and safeguarding authority had previous

substantiated concerns about how people's skin was being looked after. Staff told us that they ensured turns took place as a matter of priority. We checked records that showed that staff were ensuring that people were being turned in a timely manner.

Requires Improvement

Is the service caring?

Our findings

People told us that staff treated them with kindness but that they did not always give them the time that they needed. One person said, "There is no time for staff to talk to you. They do try to listen but they get caught up in other things." Another said, "It doesn't leave any time for talking." Relatives gave mixed feedback. Comments included, "Some staff are caring but some aren't. A lot of staff have left, they seem to be always doing paperwork instead of talking to residents." "The staff mean well but it is just slapdash. They are absolutely not professional" Staff told us that they did not have the time to provide the level of care that they wanted to. One staff member said, "The amazing times are when we get things done and we can talk to the residents and talk about their lives". A visiting health professional told us, "They are caring girls." During our inspection we observed several examples of considered and compassionate care.

We received mixed views about whether people received the care that they wanted. One person told us, "They are caring up to a point, not really doing things how I like them done. The washes they give me don't seem sufficient." However another person said, "The staff are good, they always help me." A third person told us, "I feel they have gotten to know me now and what I like. I don't think I have a nurse specifically allocated to me and it's a shame as there are so many different ones and I don't get to know them well enough really." It was not clear that people had involvement in their care planning.

People were not always supported to maintain their personal appearance to the standard that they would like. We observed that a person using the service had spilt some food during their meal. Staff had offered to help change them into fresh clothes. One relative told us, "They wouldn't normally change her, it's because the inspectors are here." Staff told us, that they didn't have the time to support people with their appearance. One staff member told us, "I don't feel I have enough time with them. At one point I was doing nails with them." They told us that when a particular person became unsettled they enjoyed staff applying cream to their legs but that this could not always happen as staff didn't have the time.

We saw that there was good signage within the building to aid orientation such as pictures on bedrooms and bathroom doors. People's doors were designed like regular outside doors to help them feel at home. The regional manager told us that people's communication was supported through the use of some picture cards and that there were plans to develop this so that people could be better informed to make decisions.

Some people were supported to maintain their independence. One person told us, "I tend to like doing things myself and they do support me to be as independent as possible." Staff understood their role in supporting independence and care plans made reference to the things that people were able to do by themselves. We saw that people were provided with adapted cutlery and crockery to enable them to have their meals independently.

People told us that staff respected their privacy and dignity but that they did not always feel that their bedrooms were respected as their own. One person told us, "They are always respectful of my privacy and knock the door. I tend to lock my door for my benefit as some ladies wander. It does make me feel like I am in prison." We observed staff knocking before they entered people's bedrooms and staff were able to tell us

the ways that they promoted people's dignity. For example ensuring people remained covered while receiving personal care.

Requires Improvement

Is the service responsive?

Our findings

People's needs were not adequately assessed to ensure that the service could meet their care needs. One person told us, "The only worry I have is talking to the poorly ones. There are a lot of poorly people." We spoke with a health professional who told us, that they had advised the registered manager that a person was not suited to be cared for at Saffron house due to their complex needs but that they had been admitted against their advice. We saw that pre-admission assessment documents were not always carried out in detail. Staff told us that people's changing needs were not always taken into account. They said, "The dependency is higher than when they first came." This meant that the services ability to cope with people who had complex needs or whose support would take a lot of staff time had not been taken into account.

People's care plans included information that guided staff on the activities and level of support people required for each task in their daily routine. We saw that the level of detail in the care plans ensured staff had all the information they needed to provide care as people wished. Care plans contained information about people's preferences and usual routines. This included information about what was important to them, their health and details of their life history. The care plans were being rewritten at the time of our inspection. The regional manager told us that this was so that they were easier for staff to understand.

Staff were required to record the support that they provided in people's daily notes. We saw that these records were detailed and reflected the support that people had requested. Important information about changes in care needs for people were shared with carers via a communication book which all staff read. Staff also shared important information regarding people's care during staff handover. This was important so that staff coming on to a shift were made aware of the well-being of each person and any important information relating to their care.

People were not supported to engage in activities that were meaningful and of interest to them. One person told us, "I would love to go to the paper shop but I can't. They can't take me either as there aren't enough of them." This shop was next to the entrance to the home. Another person said, "They have brought in a lot of poorly ones who don't mix which is one reason I don't take part in things." A third person told us there was "Not enough to keep you occupied." We asked staff if they thought that people had enough to do. One told us, "I think they could possibly do more." The service employed an activities co-ordinator to support people with activities however on the second day of our inspection we were told that they were delivering care rather than activities on that day due to the care staff being short staffed. We did observe some activities taking place during our inspection such as a ball game and singing. However we also observed periods of time when people in the lounges were provided with no stimulation or interaction. The television was switched on but turned down so residents could not hear it. We spoke with a visiting health professional who told us that they felt that people's lack of activity had a detrimental effect on their behaviour and levels of anxiety. The first day of our inspection took place on the day of the European Union referendum. We asked if people were being supported to vote and were told that they were not.

People's views were not always asked and acted upon. One relative told us, "I have not been asked my views but I have been to a residents meeting and I have raised the problem of staff shortages. I don't think

anything was done." Another relative told us, "We haven't been asked for any feedback. We had a word with [regional manager] and he just advised us to press the buzzer but we always have to wait such a long time!" Relative told us that they had raised concerns with the registered manager but these had not been addressed. The service has a complaints procedure that was available to people who used the service but this was found to require reviewing as some of the information contained within it was out of date. We saw that there had been two formal complaints recorded and that these had been addressed in line with the service procedure. However relatives and staff told us that they believed other complaints had been made. One person told us that they had made a complaint to the manager and they had addressed it to their satisfaction. We could not see that this complaint had been recorded. The registered manager told us that they would record all complaints verbal and written in the future.

We saw that a suggestions box and complaints forms available in reception however this area was not easily accessed for most residents. We saw that people were kept informed via a newsletter. This contained information about activities that were coming up and people's birthday celebrations.

Requires Improvement

Is the service well-led?

Our findings

Providers are required to ensure that CQC is informed of significant events that happen in the home. We identified incidents of physical assault, injuries, serious pressure sores and potential sexual abuse which we had not been notified of

This constituted a breach of Regulation 18 of the Care Quality Commissions (Registration) Regulations 2009

The registered manager had failed to ensure that robust records and data management systems were in place. For example we found that staff training records were not kept up to date. Systems had not been put in place to ensure that staff had the required training prior to them supporting people and this was not monitored. Staff told us that they had not been able to access training courses due to them being required to work on training days. Records relating to DoLS authorisation requests were not maintained. This put people at risk of being unlawfully restrained.

The registered manager was required to conduct daily audits within the home. They would check on staff as per rota, cleanliness of the home, observe of interaction between people and staff and check records. We saw that these audits were not consistently completed. Where concerns had been identified by the registered manger it was not clear what action had been taken. For example we saw that on three occasions over six days, gaps had been found in the recording of how people received their creams. One the day of our inspection we were told that cream records were not in place. This meant hat systems were not in place that the quality of the service that people received was not adequately monitored and action taken to address concerns when they arose.

The registered manager completed monthly audits of systems within the home such as medication systems, care plan records and catering facilities. We were able to see that concerns had been identified during these audits. It was not clear what action had been taken to address the concerns raised. We saw that action had not always been taken when the need was identified by outside professionals. For example we saw that a food hygiene inspection in November 2015 had suggested a few areas for improvements. These had not been implemented.

These matters, along with concerns regarding complaints, constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that the service was not well led. One person said, "The manager is not a good manager at all. I have only spoken to him three times. He hardly speaks to the staff. I never see him and I have no faith in him. Another person said, "I know who the manager is. I see him about but not to speak to." A relative said, "I wouldn't say it is particularly well run. I know who the manager is but he is mostly in his office. He doesn't know how to interact with people." Another relative told us, "We don't think the management are very professional. The staff are wound up by the managers. There is a distinct air of discontent."

Staff told us that they did not feel supported by the registered manager. One said, "Staff are leaving. We

have been under-staffed for months, there's a constant change in paperwork, it's too much". Another told us, "Over the past few months it's not been satisfactory. We've not had the support. Since the area manager has been things have picked up. The manager needs support".
Staff told us that they did not have faith that the registered manager would deal with their concerns. One told us, "I've reported certain members of staff not doing what they should and he's (manager) done nothing, they should support us".

Staff told us that they were invited to attend staff meetings but that these only occurred as a result of concerns raised at the home. One staff member said, "Sometimes but only when bad things happen". Another told us, "Staff meetings and 1-2-1s are a bit weak. You fill in the paperwork and then they don't happen. We don't really get a lot of team meetings". Many staff told us that they had complained about the staffing levels at staff meetings but that this had not been taken seriously. Staff meeting minuets did not confirm this, we saw that a meetings had occurred in January and April.

The regional manager was based at the home at the time of our inspection. They told us that this was in order to monitor the activities that were taking place, support the registered manager and to support the staff team in the implementation of new care planning documentation. Staff told us that having the regional manager at the home more regularly had been helpful and they felt more supported as a result. One staff member said, "Anything I need I can go to [regional manager]." The regional manager intended to remain in based at Saffron house until such time as they felt the additional support was no longer required.

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 The registered manager had failed to make us aware of significant events within the service.

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 People were not always protected from harm and abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager had failed to adequately assess, monitor and mitigate risk relating to health, safety and welfare of service users and maintain complete and contemporaneous records.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff to keep people safe