Eastbourne & District Mencap Limited

Sedgemoor & Framley

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

Sedgemoor and Framley provides support and accommodation for up to 23 young adults with learning disabilities, autism and mental health issues. The home is one of three homes that are owned by the Eastbourne and District Mencap charity. It is comprised of two houses enjoined by a link building and a separate bungalow to the rear that is used by two people. There were 18 people living in the home during the inspection and all required some assistance with looking after themselves, including personal care and support in the community. People had a range of care needs, including living with dementia; some could show behaviour which may challenge and some were verbally unable to share their experience of life in the home because of their learning disability.

A registered manager had not been in place since August 2015 and the charity's operations manager had taken on day to day responsibility for the management of the home. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are

Summary of findings

'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.

This inspection took place on the 18, 19 and 26 November and was unannounced.

An effective quality and monitoring system was not in place, which meant the issues identified during the inspection had not been identified and acted upon. This included staffing, care plans and daily records and, the management of medicines.

The provider had not informed CQC of incidents that had occurred within the home, which may have affected the support provided.

The staffing levels were not appropriate and the staff did not have the skills and expertise to show that people's needs were met. Staff had attended training, but this was not up to date and some staff had not completed induction training.

Staff had an understanding of the Mental Capacity Act 2005 and the need to support people who did not have capacity to make decisions. However, these had not been updated as people's needs had changed.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The management and staff had attended training and had an understanding and Deprivation of Liberty Safeguards. Staff had followed current guidance by making appropriate referrals to the local authority for DoLS assessments

Staff had attended safeguarding training and demonstrated an understanding of abuse and how to protect people.

Pre-employment checks for staff were completed, which meant only suitable staff were working in the home.

People had access to health professionals as and when they required it. The visits were recorded in the support plans with details of any changes to support provided.

Staff had a good understanding of people's needs and treated them with respect and protected their dignity when supporting them. A range of activities were available for people to participate in if they wished. People were able to choose what they ate and where and, relatives said the food was very good

A complaints procedure was in place. This was displayed on the notice board near the entrance to the building, and had been given to people and their relatives.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration Regulations 2009). 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 consistently safe.

The staffing levels were not sufficient and staff were unable to evidence that they met people's needs.

Risk to people had been reviewed and updated as people's needs had changed.

The systems for the management of medicines were not consistently safe.

Recruitment procedures were robust to ensure only suitable people worked at the home.

Staff had attended safeguarding training and had an understanding of abuse and how to protect people.

Is the service effective?

Requires improvement

The service was not consistently effective.

The training plan was not up to date and not all staff had completed induction training.

Mental capacity assessments had not been reviewed and updated as people's needs changed.

Staff had an understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People were provided with food and drink which supported them to maintain a healthy diet.

Staff ensured people had access to healthcare professionals when they needed it.

Is the service caring?

Requires improvement

The service not consistently caring.

Staff did not ensure that information about people's needs and how these were met was kept confidential.

The staff approach was to promote independence and encourage people to make their own decisions.

Staff communicated effectively with people and treated them with respect.

Staff ensured that people's equality and diversity needs were respected.

People were encouraged to maintain relationships with relatives and friends, and they were able to visit at any time.

Summary of findings

Is the service responsive?

Requires improvement 

The service was not consistently responsive.

The care planning system was not robust and did not reflect people's need or the support provided.

People decided how they spent their time, and a range of activities were provided depending on people's preferences.

People and visitors were given information about how to raise concerns or to make a complaint.

Is the service well-led?

Requires improvement 

The service was not consistently well led.

The quality assurance and monitoring system was not robust and did not identify areas where improvements were needed.

There was no clear leadership and guidance for staff.

People, staff and relatives were encouraged to be involved in developing the support provided.

Sedgemoor & Framley

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was unannounced and took place on the 18 and 19 November 2015 and, to ensure we had access to relevant information was completed on 26 November 2015. The inspection was carried out by an inspector and an expert by experience in learning disabilities. An expert by experience is a person who has personal experience of using or caring for someone who used this type of service.

Before the inspection we looked at information provided by the local authority, contracts and purchasing (quality monitoring) team. We also looked at information we hold about the service including previous reports, notifications, complaints and any safeguarding concerns. A notification is information about important events which the provider and/or registered manager are required to send us by law.

As part of the inspection we spoke with all of the people living in the home, four relatives and eight staff including the operations manager. We observed staff supporting people and reviewed documents; we looked at three care plans, medication records, three staff files, training information and some policies and procedures in relation to the running of the home.

Some people who lived in the home were unable to verbally share with us their experience of life at the home due to their disabilities. Therefore we spent a large amount of time observing the interaction between people and staff, and watched how people were cared for by staff in communal areas.

Requires improvement

Is the service safe?

Our findings

Relatives said people living in Sedgemoor and Framley were safe. One relative told us, "Yes my relative is safe there. The staff are very good and know what people can do in a safe way, without stopping them doing things." Staff said they had attended training in safeguarding and supporting people with learning disabilities and demonstrated an understanding of supporting people safely. Relatives were concerned about the changes in the staff team in recent months and the effect this may have on people living in the home. Staff were equally concerned and said there were not enough permanent experienced staff. Despite people sharing positive views about how safe they felt people were, we found that improvements were needed to make sure people were safe at all times.

Risk assessments had not been reviewed or updated and some information in the care plans did not reflect people's current needs. For example, one support plan showed that a person was fully active, went into town shopping, attended the day centre and used the hoover. From our observations and talking to staff the person no longer went out of the home and they were unable to participate in activities in the home, like keeping their room clean and tidy. Another person who was living with dementia needed support from one member of staff at all times to keep them safe and the provider and staff were aware of this. However, there were not enough staff working in the home to support this person on a one to one basis, they had been at risk and had two falls. We asked the provider if they had referred this to the local authority as a safeguarding issue and they did this during the inspection. The lack of up to date information about people's needs and the changes in the staff team meant people may not receive the support they need and want and, may be at risk of harm.

Four senior staff had resigned from the home over a six week period from August 2015. To assist the staff at Sedgemoor and Framley two senior support staff had been transferred from other homes in the group. They said this would be until new staff had been appointed and expected to return to their permanent posts before Christmas. We were told they would remain until at least January 2016 because the provider had been unable to recruit enough staff to meet people's needs. Bank and agency staff had also been employed to support the permanent staff. They told us they had worked at the home before and had an understanding of people's support needs. Relatives and staff said the resignations had had an effect on people living in the home, because they had worked at the home for many years, some over 20 years, and knew people and their relatives very well. Relatives told us, "Any changes are difficult and when so much changes quickly it is bound to affect people and we can't always tell us how they feel about it." "I feel they're quite short staffed sometimes" and, "A lot of experienced staff have gone, it's all up in the air at the moment." Staff told us people had been getting used to the staff leaving, but it was not ideal to have different staff working in the home because, "People need continuity." The charity's operations manager said he had taken on the role of managing the home on a day to day basis and also supported people when there were not enough staff available. This meant the staff may not have been able to ensure people's needs were met.

Accidents and incidents were recorded and staff said action was taken to identify how these occurred and how to prevent them happening again. However, one person had had two falls and these had not been recorded in the accident records. Staff said, "We haven't got round to writing it up yet, but we will when we have time." Staff had not used the accident process that was in place, to assess who was at risk of falls and plan appropriate support to reduce the risk of falls and keep people as safe as possible.

We saw staff on the night shift moved all the evening medicines from the locked cupboard onto a desk in the office. Three people were waiting in the office for their medicines and the staff member was putting out medicines into pots. We asked who the medicine was for as it was not for one of the people waiting in the office; the member of staff told us who they were for and that they would take the medicines to each person individually. They said the other member of staff would make sure the medicines were safe. However, there were only two members of staff on at night and both could be called by people to assist them in different parts of the home. Staff did not follow the policy for the administration of medicines. Keeping medicines on the desk in the office was not a safe practice; people may have been able to access them and therefore were at risk of harm by taking medicines that were not prescribed for them.

The provider had not ensured safe care and treatment for people. There were not enough staff with a clear understanding of people's needs; the system to record and

Requires improvement

Is the service safe?

reduce the risk of falls was not used correctly and the provided did not ensure the proper and safe management of medicines. This is a breach Regulation 12 of the Health and Social Care Act 2008 (Regulation Activities) Regulations 2014).

The home was two older converted buildings with bedrooms on two floors and a bungalow to the rear. Staff said they provided a safe environment that enabled people to live comfortably. There was ongoing replacement and repairs in the home and on the first day of the inspection the floor in one part of the building was replaced. Staff said other planned improvements included replacing the furniture in one of the dining rooms and redecorating it. We found that a shower unit, used by people who have epilepsy had a glass door. This meant the person may be at risk of injury if they are unwell when using the shower, the operations manager said this would be reviewed immediately.

There were records to show relevant checks had been completed, including lighting, hot water, call bells and electrical equipment. Fire system checks were carried during the inspection, batteries were replaced as part of the process and records showed that staff had attended fire training. The health and safety checks of the building were clear and up to date. However, the member of staff responsible for this said they no longer had the time to do these; they were concerned that this might affect the safety of people and staff and the operations manager was aware of this.

Staff explained how medicines were ordered, given out and disposed of if not needed, and we examined the Medicines Administration Record (MAR) charts. Medicines were delivered and disposed of by an external provider and the management of this was safe and effective. People's medicines were kept separately in locked cupboards in a side corridor. A fridge was available for medicines that required a cooler temperature and this was monitored to ensure medicines were correctly stored and safe to use. The MAR charts contained photographs of people for identification purposes, with details of allergies, and there were no gaps in the records. Staff were knowledgeable about the medicines they were giving out and had attended training. Staff had a clear understanding of the home's policy with regard to as required medicines (PRN), such as paracetamol for pain, and the reasons why PRN medicines were given were recorded on the MAR. Staff said they asked people and assessed them, through body language and expressions, to see if they were in pain.

Staff said they encouraged people to be as independent as possible. They had an understanding of risks to people and provided examples of people's unpredictable behaviour and how they were supported to make decisions about how and where they spent their time. Staff had received safeguarding training and had an understanding of different types of abuse and, they told us they had read the whistleblowing policy and said would report any concerns to senior staff. If they felt their concerns had not been addressed to their satisfaction they would contact the local authority or CQC. Staff told us they had not seen anything they were concerned about and were confident if they did action would be taken. Relatives had no concerns about people's safety and they had not seen anything they were worried about. One relative told us, "People are safe here even with the changes in staff."

Recruitment procedures were in place to ensure that only suitable staff were employed. We looked at the personnel files for three staff. These contained relevant checks on prospective staff's suitability, including completed application forms, two references, interview records, evidence of their residence in the UK. A Disclosure and Barring System (Police) check, which identify if prospective staff had a criminal record or were barred from working with children or adults, had been completed for all staff. Staff said they had completed application forms and sent in CV's, references had been obtained and checks had been completed. One member of staff said this made sure only the right people worked at the home.

The provider had plans in place to deal with an emergency. There was guidance in the care plans for staff regarding the action they should take to move people safely if they had to leave the home at short notice.

Requires improvement

Is the service effective?

Our findings

People said the food was very good and they could have anything they wanted. One person told us, "I like the food very much and I help in the kitchen sometimes." Staff said people chose what they wanted to eat and snacks were available throughout the day; they had a good understanding of people's preferences and told us people's nutritional needs were met. Ongoing training was provided for staff and they told us they had the skills and experience to provide the support people needed and wanted. Relatives said, "I think they are doing a good job on the whole" and, "I know may relative is happy as he is always ready to go back after a visit home."

Staff had completed training and had a good understanding of the Mental Capacity Act 2005 (MCA). The MCA aims to protect people who lack capacity, and enabled them to make decisions or participate in decisions about the support they received. Mental capacity assessments had been completed for the people living in Sedgemoor and Framley as part of their support plan. Staff said people were able to make some decisions about their day to day lives such as when to get up, what to eat and when they went out; but they were unable to understand more complex decisions, such as when they might need to see their GP or if they needed additional support with personal care and assistance when going shopping. However, the care plans had not been reviewed and updated as people's needs changed which meant staff may not be aware of people's ability to make decisions and may not provide the support they need. For example, staff said one person's needs had changed and they were no longer able to make decisions about any aspect of their day to day lives, but the mental capacity assessment had not been reviewed and the support plan had not been updated to identify how this person's need would be met.

Permanent staff had completed an induction programme when they started work at the home. This had included reading the support plans, the procedures and policies and, they had been supported by more experienced staff until they had been assessed as competent and felt confident to look after people on their own. However, the staff transferred from other homes in the group, bank and agency staff had not been completed induction training. They told us they worked with permanent staff and asked them how to provide the support people needed. Staff were not aware of the Skills for Care Certificate; the operations manager said all new staff would be required to do this as part of the induction training, although there were no systems in place to start this training.

Staff said they were required to attend the training provided and were supported to work towards national vocational qualifications if they wanted to. The training plan showed staff had attended fundamental training, including moving and handling, first aid awareness, food hygiene, health and safety, safeguarding and medication although some needed updating. The provider was aware that some training needed to be reviewed and the operations manager said this was being arranged.

Records showed that supervision had been provided before the changes in staffing at the home but, at the time of the inspection there was no supervision programme in place. The operations manager said this would be reviewed and arranged as soon as possible, although this may be when a manager was appointed to run the home on a day to day basis.

Staff told us, "We know how much support people need and we ask them if we can assist them, if they say no we leave them and go back later or get someone else to support them." "Some people understand they need our support and they need us to be with them but, they decide what they are going to do and some know that staff will help them to what they want." One person said, I can't go shopping on my own," staff asked them if they wanted to go shopping and went with them and two other people. When they returned they said they had enjoyed going into town; had bought what they wanted and put it away in their cupboards.

Deprivation of Liberty Safeguards (DoLS), which is part of the MCA, is to ensure someone, in this case living in a care home, is deprived of their liberty in a safe and appropriate way. This is only done when people are unable to tell staff about their wishes and need support with aspects of their lives. Decisions about their support is made during best interest meetings and agreed by relatives, health and social care professionals and staff, when there is no other way of safely supporting them. Relatives said they had been involved in discussions about people's changing needs and understood that to ensure people were safe there may have to be some restrictions on what they can do. Relatives told us, "I'm happy he is in the right place, it is quite far for us, but it is the right place." "I would know if things weren't

Requires improvement

Is the service effective?

ok, my relative is very happy, he has told me" and, "my relative needs to be safely cared for in the home." DoLS had already been agreed with the local authority for the locks on the front doors and applications had been sent for the gates across the kitchen doors. Staff said these were to support two people who had been assessed as being at risk. One person had previously eaten too much and was ill as a result and, the other person was not aware of the risks associated with kitchen equipment. This showed that systems were in place to support some people.

Staff demonstrated an understanding of people's support needs, they discussed how they enabled people to be independent and were clear that if people's needs changed they would contact senior staff or on call staff if this occurred in the evening or at night. Staff were aware that some people were unable to communicate verbally and they showed that they had learnt to, "Read their sounds, they all mean different things" and, one member of staff used Makaton although the provider had not provided training. Makaton is a system of using signs and language to communicate with people who may be unable to communicate verbally.

Choices were offered for each meal and some people joined staff as they prepared the meals; people laid the tables, put out cutlery and condiments, and cleared the tables after meals. A rota system was in place and people were aware of whose turn it was to assist staff, although some people were unable to do so and people and staff were aware of this. Packed lunches were made for people going to the day centres and people who remained at the home chose what they wanted to eat. One person required a gluten free diet and appropriate food was provided. The atmosphere during meals was relaxed and sociable, people supported each other and staff were available to prompt and assist people if required. One relative said the food was very good, "They seem to enjoy it and I haven't had any complaints about it."

People had access to health care professionals as and when they were required. These included the community learning disability team, dentists and chiropodist. GPs visited the home as required; staff said they could contact them if they had any concerns and staff attended hospital appointments with people or arranged for relatives to go with them. A relative told us a medical assessment was due for their family member because their needs had changed and this was being arranged. One person had a hospital appointment and they said a member of staff would be going with them.

Requires improvement

Is the service caring?

Our findings

People living in the home were relaxed and comfortable, they talked to staff on first name terms and communication between them was friendly. Staff treated people with respect and enabled them to make decisions about the support provided. Relatives said people were well cared for and people were happy. People spent their time as they wished and relaxed in the lounges, in their bedrooms, or walked around the home if they preferred.

Staff said information about people was confidential and they had been given a copy of the confidentiality policy. They told us they never discussed people's support needs with other people or their relatives, and made sure if they had to talk about a person's needs they did this in private. Staff said, "We don't talk about other people's needs with anyone other than them, their relatives and other people if necessary. Like their doctor." However, we saw one person was able to sit in the office during handover, when staff discussed how people had spent their day, if their needs had changed and the support provided. Staff told us the management had allowed this person to remain in the office when not attending the day centre, although other people were removed from the office during handover. Staff said, "They sit in the office drawing and have some of their meals there." "They are more relaxed there, they get upset if they are asked to leave." "It has been going on for a long time" and, they didn't, "get involved in the discussions, but can hear what we say." Staff were unable to show that information about people's needs remained confidential.

People were able to make decisions about all aspects of their day. As part of their 'training day' people were encouraged to be involved in household activities. There was good interaction between people and staff when they were in the kitchen preparing meals and in the laundry room doing their own washing. Staff said the level of support varied depending on people's abilities to participate in the chores and, we saw they had an understanding of each person's ability to participate in the running of the home. Some people assisted with the preparation of meals and their own snacks, staff had their meals with people and supported them in a gentle, caring and respectful way. Staff told us, "We are like one big family" and, "I become very fond of people I work with." "We make sure people are as independent as they can be. I am keyworker for one person and I know their needs have changed and I know what they can do and what they cannot do" and, "I like to support people to do what they want and I think we all do that very well. We do not make decisions for them, the most we do is offer choices."

A keyworker system was in place and each person was supported by a member of staff. Staff told us, "We make sure they have everything they need. We don't buy things for them, like drinks or toiletries, but if they need something we go shopping with them or tell their relatives." People went shopping at different times during the inspection. One person said, "I got what I needed and I like shopping."

Some people were unable to communicate verbally and staff demonstrated an understanding of their needs by observing their body language and facial expressions. One person had a very short attention span and at times did not recognise staff and people around them. There was hesitation when some staff assisted this person, but overall interaction was positive and appropriate support was provided. Staff respected people's privacy and dignity when offering assistance with personal care, they spoke quietly and guided and assisted people to use the bathrooms or return to their rooms.

Staff had not attended equality and diversity training, but they had an understanding of the issues and their implications for the people they supported. Staff told us, "We spend a lot of time with people and understand the support they need, but people make their own choices and if they do not need our assistance then we respect that." "We know people's likes and dislikes and as much as possible they make decisions about the support they have" and, "People decide what to do, some do housework while others choose not to, and some people's needs have changed so they can no longer go out or choose not to."

Relatives said they could visit at any time and were always made to feel very welcome and that the home provided the care people needed. They said, "I think it is the best place for my relative." "All the residents seem very happy when I visit." "It's run so well, with nice caring people" and, "I feel my daughter is well cared for." Staff knew the relatives very well and there were friendly conversations between them when they visited the home. One relative told us, "We can

Requires improvement

Is the service caring?

talk to the staff any time and this is very important, so that we are confident people are cared for during a difficult time for the home. And I feel confident they are cared for despite the problems."

Staff told us there were systems in place to support people if they did not have relatives or representatives. Information about advocates was available in the office, although staff said they were not needed.

End of life care was included in the care plans and relatives had spoken with staff to ensure that people could remain at Sedgemoor and Framley if their health care needs changed. One relative said they had been assured their family member would be able to stay at the home and were confident this would be arranged.

Requires improvement

Is the service responsive?

Our findings

People were involved in decisions about the support provided and relatives said discussions about people's support needs and how these were met had taken place. One relative said, "It is easy to get hold of staff if we want to talk about anything and they are always very helpful." Relatives knew how to make a complaint, although they also said they had no complaints, "Only concerns about the changes in staffing, which we understand they are dealing with."

Staff said people's needs had been assessed before they moved into the home and these assessments were in the care plans. However, staff working in the home during the inspection had not been involved in writing the support plans; some staff were in the process of reviewing and updating them, but there was no clear information about some people's needs and how these were met. For example, one person walked around the home picking up any drink they found, other people's and staff, and drank them. Staff said this was something the person had done since they had moved into the home and staff and people automatically picked up their drinks when this person walked near them. Staff said they had talked about this, but had found that distraction techniques had not been effective and, the person had not been referred to an appropriate health professional for assessment and development of a support plan. This meant staff may not have provided appropriate support for this person and their needs may not have been met.

There was a daily record folder for staff to record the support they provided as well as any changes in people's support needs, how they had spent their day, their mood and how they felt. However, most of these were blank, therefore there was no evidence that staff provided the support they discussed or that they had met people's needs. Staff said they completed these when they had the time. This meant there was no record for staff who had been on holiday or absent to refer to and identify if people's needs had changed and, people may not have received the support they needed.

One person's needs had changed and staff had contacted the local authority who was responsible for them moving into the home, and they were waiting for a response. The operations manager had tried to set up a meeting to discuss the person's needs, so they were sure the support provided met their individual needs. This showed the staff were actively involved in setting up reviews of some people's support needs, to ensure their needs could be met.

One person said they went home regularly to see their relatives and people were encouraged to maintain relationships with people that mattered to them. One relative said their family member had spent more time with them because of the staffing issue, but they were very satisfied with the support provided and had no complaints.

Relatives said they had been invited to join the staff and health and social care professionals to discuss their family member's needs and what was the best way to meet them and, there was some evidence of their involvement in the support plans. We found that some of the information recorded had not been reviewed and updated and the operations manager was aware that these discussions should be recorded. One relative said they had no trouble voicing any concerns if they had any. All of the relatives spoken with said the support provided from the management and staff was good. They also said they had not been involved in developing or updating the care plans, although they also thought they were up to date.

People attended a day centre at least one day a week, if they chose to. These were recorded on the board in the office, as well as trips out and training days and people looked at these, "To see what I am doing" and, discussed them with staff. Staff had arranged for two people to visit a person who had moved to another care home and people told us they were looking forward to going and had bought gifts for them. People said they liked going to the day centre, they enjoyed the work they did and what they had learnt, they also liked to have the weekends off. One person said, "We don't work weekends, so we can have a lie in if we want." Another person said they really enjoyed just relaxing and watching TV. People spent the evenings watching TV, playing games on their laptops or talking in one of the lounges. A range of activities were available and people said they could choose what they wanted to do. People who were unable to make choices were encouraged to join in, and staff supported people to ensure no one was isolated. Staff spent time with people who preferred to remain in their rooms, and staff discussed what people were doing after they returned from the day centres and, were aware of how people were spending their time.

Requires improvement

Is the service responsive?

People's rooms had been decorated in the colours of their choice and photographs and ornaments personalised the rooms. People said they liked their rooms and invited us to look at them.

A complaints procedure was in place in pictorial format for people living in the home to use if they wished. A copy was displayed in the home and given to people and their relatives. Relatives told us their only concern was the staffing and they said, "The management are doing something about this." Staff said if there were any concerns it was usually about something they could deal with at the time, such as the food, people had changed their mind and an alternative meal was provided. We looked at the complaints folder and there was a system in place to address concerns and complaints.

Requires improvement

Is the service well-led?

Our findings

From our discussions with relatives, staff and the operations manager and, our observations, we found the culture at the home was relaxed and the environment was pleasant and comfortable. People living at Sedgemoor and Framley were encouraged to make choices and they decided how they spent their time. Relatives and staff said they had concerns about the changes in staffing in the home, but they also knew that the operations manager was actively recruiting new staff.

The registered manager, deputy manager and two senior support staff had resigned during September and October 2015. The charity's operations manager had taken on the responsibility for the management of the home on a day to day basis and had been actively advertising for staff. They told us that the staff leaving was outside their control and they were actively recruiting a manager, deputy manager and support staff. Their expectation was that a deputy manager would be in place in the new year. Although they realised that staffing issues may take time to resolve as new employees may have to give notice to their current employer. Staff said there were no clear lines of accountability and they were not aware of their own responsibilities, although they understood people's support needs and told us they met them. They had concerns about how the service would develop.

The provider did not have an effective quality assurance and monitoring system in place. This meant that the issues identified during the inspection had not been identified and appropriate action had not been taken to address them, including staff training, records, support plans and audits. The operations manager was aware that the monitoring of the service had not taken place in the previous two to three months. They said their priority since the registered manager, deputy manager and two senior support staff had left had been to make sure, as much as possible, that the support provided was not affected by the lack of staff. This meant they concentrated on providing support and had been unable to keep up to date with records and support plans and, because the audits had not been completed they had not been made aware of any gaps or areas for improvement.

Staff told us the provider had reviewed the staffing levels at the home and the expectation was that these will be reduced and, they felt any changes would be due to financial decisions rather than making sure people's needs were met. The operations manager said they were reviewing the staffing levels and, they assured us sufficient staff would be employed to work at the home to meet people's needs

The lack of an effective quality assurance and monitoring system is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider and registered manager are required, by law, to inform us of any important events that occur in the home, which may affect people living in the home and the support provided. We found during the inspection that incidents had occurred. For example, staff said there had been two referrals to the local authority under safeguarding. These had occurred some months before the inspection and staff were not sure of the details. In addition, the provider was required to inform CQC if there was 'an insufficient number of suitably qualified, skilled and experienced persons being employed for the purposes of carrying on the regulated activity'.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration Regulations 2009).

Staff said there had been one meeting and they had talked about changes and staffing. They told us they did not feel that they had been consulted when decisions had been taken to reduce the staffing and, although they had raised their concerns about how reduced staffing levels may affect the care and support people received they did not feel they had been listened to by the provider. The minutes from the meeting were not available. Staff also said senior staff and the operations manager were always available and had been very supportive, "During a difficult time." The operations manager said they had been informed the staff about any changes that were planned and they had been available to discuss any concerns staff might have at any time.

The operations manager said feedback was sought from people living in the home, their relatives or representatives and health professionals continually and they felt this had continued.

Relatives were aware of the changes in staffing levels and had discussed their concerns with the staff and operations manager. They told us they had noted the behaviour of their family members had changed and staff had been

Requires improvement

Is the service well-led?

aware of this and had acted appropriately to support them. Their concerns were about the future of the home and if more staff left how this might affect people living in the home. One relative said, “We have to wait and see what happens really. At the moment things are ok, but they could be better for everyone.”

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 Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. The provider had not safeguarded the health, safety and welfare of people living in the home by ensuring there were safe systems in place to support people at risk. Regulation 12 (2)(a)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance. The provider did not have an effective monitoring and assessment system in place to ensure that people were protected against inappropriate and unsafe care and support. Regulation 17(2) (a) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents Regulation 18 HSCA 2008 Registration Regulations 2009. The provider had not fulfilled their statutory obligations to the CQC with regard to notifications. Regulation 18 (2)b(ii) 2e.