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Cloneen Care Home

Inspection report

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Date of inspection visit:
17 January 2017
18 January 2017
30 January 2017

Date of publication:
15 March 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 17 January 2017 and was unannounced. This meant the registered provider and staff did not know we would be visiting. Second and third days of inspection took place on 18 and 30 January 2017 and were announced. The service was last inspected in June 2016 and was meeting the regulations we inspected at that time.

Cloneen Care Home provides care and accommodation for up to 15 older people and/or older people living with a dementia. Cloneen is a converted Victorian house in a residential area of Saltburn. There is a communal lounge and dining room on the ground floor of the home. The service is close to shops, pubs and public transport. At the time of our inspection nine people were using the service.

There was a manager in place but they were not a registered manager and their role had recently been changed to that of a full-time care assistant. However, as well as their new care role they were still responsible for managing the service. The manager was only able to carry out their management role in their own time. 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.

Before the inspection we received feedback on the service from the local authority, who raised concerns about staffing levels at the service. We were also contacted by the police, who raised similar concerns. Our judgment following inspection was that staffing levels were not sufficient as too few staff were deployed to administer medicines at night, to allow staff to have proper breaks and to properly supervise people requiring two to one support.

The registered provider's recruitment processes reduced the risk of unsuitable staff being employed. Risks to people using the service were assessed and plans put in place to reduce the chances of them occurring. Regular checks of the premises and equipment were made to ensure they were safe for people to use. Plans were in place to support people in emergency situations.

Safeguarding policies and procedures were in place to protect people from abuse. People's medicines were managed safely.

People were not always supported to access external healthcare professionals to monitor and promote their health. Staff received the training needed to support people effectively and were supported through regular supervisions and appraisals with the manager. Staff understood and applied the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) to protect people's rights. People were supported to maintain a healthy diet.
People spoke positively about staff and the care they received at the service and told us they were treated with dignity and respect. Staff knew the people they supported well, which meant they could have

interesting and meaningful conversations with them. We saw numerous examples of kind and caring interactions between staff and people at the service.

People were supported to access advocacy services. At the time of our inspection no one at the service was receiving end of life care. However, people's wishes were recorded in their care plans.

People's care was person-centred and was regularly reviewed to ensure it reflected people's current needs and preferences. We received mixed feedback on activities at the service. Some people were content with the activities, but others said they would like to go out more. Staff thought people would benefit from being taken out more but staffing levels did not allow for this.

There was a complaints policy in place. People told us they knew how to complain about issues.

The manager and registered provider carried out a range of quality assurance checks to monitor and improve standards at the service. Staff told us they felt supported by the manager, but not always by the registered provider. We saw from records at the service that we had not always received required notifications about safeguarding incidents. We reminded the manager and registered provider of the requirement to submit notifications. Feedback was sought from people using the service and staff.

We identified one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 during our inspection, in relation to staffing levels. You can see what action we took at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe due to low staffing levels.

Risks to people using the service were assessed and addressed.

Policies and procedures were in place to protect people from abuse.

People's medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported to access external healthcare professionals to monitor and promote their health.

Staff received the training they needed to support people effectively.

Staff were supported through regular supervisions and appraisals.

Staff understood and applied the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) to protect people's rights.

Is the service caring?

Good

The service was caring.

People spoke positively about the care and support they received.

Staff treated people with dignity and respect.

Throughout the inspection we saw kind and caring support being delivered.

People were supported to access advocacy services where appropriate.

Is the service responsive?

Requires Improvement

The service was not always responsive.

We received mixed feedback from people and staff about activities, particularly external activities.

Care planning and delivery was usually based on people's needs and preferences.

The service had a complaints policy and people relatives said they would use it.

Is the service well-led?

Requires Improvement

The service was not always well-led.

We had not always received required notifications from the service.

Staff said they were supported by the manager but not always by the registered provider.

The manager and registered provider carried out a range of quality assurance checks to monitor and improve standards at the service.

Feedback was sought from people using the service and staff.

Cloneen Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 17 January 2017 and was unannounced. This meant the registered provider and staff did not know we would be visiting. Second and third days of inspection took place on 18 and 30 January 2017, and were announced. The service was last inspected in June 2016 and was meeting the regulations we inspected at that time. The inspection team consisted of an adult social care inspector 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 reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

The registered provider was not asked to complete a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We contacted the commissioners of the relevant local authorities and the local authority safeguarding team to gain their views of the care provided by Cloneen Care Home. We received feedback from the local authority and also from the police, both of whom raised concerns about staffing levels at the service.

Some people using the service had limited verbal communication but were able to communicate in other ways. During the inspection we communicated with five people who used the service. We looked at two care plans, medicine administration records (MARs) and handover sheers. We spoke with seven members of staff, including the registered provider, the manager and care staff. We looked at two staff files, which included recruitment records.

Requires Improvement

Is the service safe?

Our findings

Before the inspection we received feedback on the service from the local authority, who raised concerns about staffing levels at the service. We were also contacted by the police, who raised similar concerns.

Staffing levels had been changed in January 2017 as a result of a fall in occupancy. At the time of our inspection nine people were using the service. Two people required 2:1 support. As part of the staffing changes the manager was working full-time as a care assistant. Day staffing levels were two care assistants from 8am to 8pm. The manager left at 5pm, so between then and 8pm another care assistant was on duty. Night staffing levels were one care assistant between 8pm and 8am. Another care assistant worked as a 'sleeping' care assistant, which meant they worked from 10pm to midnight, then from 6am to 8am. They slept between those times, though could be woken to assist with emergencies.

We reviewed staff rotas. These showed that overnight there was not always a care assistant trained to administer medicines. Some people at the service were prescribed pain relief, and we asked the manager who would administer that if a person needed it at night. The manager told us a member of staff who administered night medicines had recently left the service, and the registered provider was recruiting a replacement. Until they were replaced the manager said they would be called out to administer night medicines. The manager said, "Yeah, that is a struggle. I have known staff to ring me to come and administer (medicines)." In addition to being on call for night medicines, we also saw there was no time allocated on the rota for the manager to carry out management tasks. They told us they did this in their own time, usually by staying back after their shift ended. The registered provider told us they assisted with the management of the service, but we could not check this as it was not recorded on the rotas.

The service had a cook but they did not work Tuesdays or Saturdays. On those days care staff were responsible for meal preparation. There were no domestic staff employed so care staff were responsible for cleaning and laundry. Including the manager the registered provider employed nine care staff and four bank staff. Sickness and holidays were covered by staff working extra shifts, though the registered provider said a nominated agency could also be used in emergencies.

People's bedrooms were spread across three floors. During the inspection everyone living at the service were in communal areas. Our judgment was that staff would find it difficult to safely monitor people throughout the building if they chose to spend time in their own rooms.

Throughout the inspection we saw staff working hard to support people. We did not see any delay in people receiving the support they needed, though during the inspection extra staff were deployed above usual staffing levels. People said there were enough staff at the service. One told us, "Oh yes, yes. They come straight away. We have good ones here. They are all nice, really, and I get my medication on time." Another person said they liked to have lots of drinks every morning and staff were, "Always happy to oblige."

Staff told us they struggled to take breaks as they were always needed to support people, and that holidays were not authorised by the registered provider. The registered provider disputed this and said staff were

entitled to and should take breaks and holidays.

Staff told us there were not enough staff employed to support people. One member of staff said, "It's a ticking time bomb" and that they worried about when the 'sleeping' care assistant at night was getting rest. When telling us about the night staffing arrangements they said, "Nights do worry me. I don't think we can have one sleeping and one caring." Another member of staff told us, "I don't think there are enough staff. It was always two carers and the manager but the manager got put onto care" and "I don't think it's right to go from the kitchen to the toilets [to support people]." Another told us not everyone working night shifts had medicine training. Another member of staff said. "I think there should be two (care) staff and the manager" and "A couple of people are on 2:1. [Night staff] try to make sure [named people] are up for the day shift." One member of staff we spoke with said there were enough staff to support the nine people using the service.

Our judgement was that staffing levels were not sufficient. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider's recruitment processes reduced the risk of unsuitable staff being employed. Applicants for jobs were required to complete an application form setting out their employment history and explaining any gaps in employment. Proof of identity was required, written references sought and Disclosure and Barring Service (DBS) checks carried out. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and adults. This helps employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with children and vulnerable adults.

Risks to people using the service were assessed and plans put in place to reduce the chances of them occurring. When people started using the service their needs were risk assessed in a number of areas, including personal hygiene, nutrition and hydration, continence, skin integrity, mobility, night care and mental health. If a risk was identified a plan was developed to minimise the risk of it occurring. Recognised tools such as the Malnutrition Universal Screening Tool (MUST) and the Braden scale were used to assess risk. MUST is a screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan. The Braden scale is used to assess people's risk of developing pressure sores. Risk assessments were regularly reviewed to ensure they reflected people's current level of risk.

Regular checks of the premises and equipment were made to ensure they were safe for people to use. These included weekly fire alarm checks, monthly emergency light checks and regular fire drills. Required test and maintenance certificates were in place for hoists and bath hoists, legionella and gas and electrical safety. The manager monitored accidents and incidents to see if improvements could be made to keep people safe. The manager told us, "I do a monthly audit showing where they took place, at what time, and look for patterns."

Plans were in place to support people in emergency situations. Each person using the service had a Personal Emergency Evacuation Plan (PEEP). The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. However, we saw these were in need of review as they were still in place for people who were no longer using the service. There was a business continuity plan in place. This contained detailed guidance to staff on providing a continuity of care in situations where the use of the building was interrupted, such as during floods or loss of utilities.

Safeguarding policies and procedures were in place to protect people from abuse. Staff had a good understanding of the types of abuse that can occur in care settings and said they would be confident to raise any concerns they had. One member of staff told us, "I would raise any concerns with the manager or with safeguarding (at the local safeguarding team)." Where issues had been raised we saw records of investigations carried out by the manager.

People's medicines were managed safely. Before people started using the service their medicine support needs were assessed and each person had a medicine administration record (MAR). Each person had their own medicine administration record (MAR). A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered.

People's MARs contained their photograph and information on any known allergies or special administration instructions. Where people had 'as and when required' (PRN) medicines, protocols were in place to guide staff on when they might be needed. Records were in place to monitor people's use of time critical medicines such as warfarin. We reviewed two people's MARs and saw there were no gaps in administration and appropriate codes were used to record why medicines had not been given. A person we spoke with said, "I get the correct tablets on time."

Medicines were safely and securely stored in a locked medicine trolley that was secured in the dining room. The temperature of the dining room was regularly checked to ensure it was within ranges suitable for medicine storage. At the time of our inspection two people were using prescribed controlled drugs. Controlled drugs are medicines that are liable to misuse. These were securely and appropriately stored and recorded.

Regular checks of medicine stocks were made to ensure people always had access to the medicines they needed. The service was audited by a local pharmacy in November 2016 and no issues were identified.

Requires Improvement

Is the service effective?

Our findings

People were not always supported to access external healthcare professionals to monitor and promote their health. People's care plans contained details of the involvement of professionals such as GPs, district nurses, podiatrists, the memory clinic and occupational therapists. For example, one person's care plan detailed how a decline in their mobility led to a referral to the occupational therapist to see what additional support could be provided. However, following our visits to the service we received feedback from an occupational therapist who had been refused entry to the service on four occasions in October and November 2016 as the registered provider wanted to be present when they visited. They had been sent to the service by the local authority to examine moving and handling care plans following a safeguarding incident. The service attempted to cancel a fifth attempt for the occupational therapist to visit, but they insisted on attending. This meant the service did not always effectively work with external professionals to promote people's health.

Staff received the training needed to support people effectively. Mandatory training was required in handling medicines, first aid, moving and handling, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS), safeguarding, dementia care, food and nutrition and infection control and COSHH. Control of Substances Hazardous to Health Regulations (COSHH) sets out how to control hazardous substances at work. Mandatory training is training the registered provider thinks is necessary to support people safely. Training was carried out by external providers, and was refreshed annually to ensure it reflected current best practice. Training was up to date for 2016 and the manager told us refresher training had already been arranged for first aid, COSHH, moving and handing and safeguarding. The manager was in the process of introducing training based on the Care Certificate, and had started this with infection control training. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It sets out explicitly the learning outcomes, competences and standards of care that will be expected.

People told us staff had the training needed to support them effectively. One person told us, "Well they know what they are doing." Staff spoke positively about the training they received and said they would be confident to request more if they felt this was needed. One member of staff we spoke with said, "Training is fine. We know how to use the equipment we need." Another member of staff told us, "We do get training. I've just done some medicine training. I think we'd get specialist training if we needed it."

Newly recruited staff completed an induction programme before they started to support people without supervision. No new staff had been recruited since our last inspection, but the manager told us this involved reviewing the service's policy and procedures and shadowing more experienced members of staff. The manager would then have a discussion with the new member of staff to see if they were confident to begin work or needed further support and training.

Staff were supported through regular supervisions and appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. Staff files contained records of supervision and appraisals, and showed staff were encouraged to raise any support needs or issues they

had. Staff told us they found supervisions and appraisals useful. One member of staff said, "We get supervisions and appraisals, though I wouldn't wait if I had any issues to raise."

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our inspection five people were subject to DoLS authorisations. This was clearly recorded in care records, and the manager was able to describe how they submitted applications where these may be needed. Two people had Deputies appointed to manage their affairs, and one person had a Lasting Power of Attorney exercised by a relative. The manager and staff were knowledgeable about when other agencies or professionals were responsible for taking decisions for people, which helped to protect people's rights.

People's care plans contained evidence of mental capacity assessments, which were decision specific. Where people did not have capacity to make decisions best interest decisions were made on their behalf by staff and we saw evidence that other professionals and relatives were consulted about this. Throughout the inspection we saw staff giving people choices over how they wanted to be supported, even where people were living with a dementia and could not decide every aspect of their care. For example, we saw a member of staff supporting someone to decide where they would like to sit by walking with them to each chair available and asking if they wanted to sit there.

People were supported to maintain a healthy diet. Before people started using the service their nutritional needs and preferences were assessed. This included seeing if people required specialist diets (for example, diabetic or pureed) and any additional support to eat. At the time of our inspection no one using the service required a specialist diet. Where people were taking medicines that might be affected by their diet this was clearly recorded in their nutrition care plans. For example, one person's care plan highlighted the fact that cranberry juice could interfere with their warfarin. People's weights were monitored to ensure they were receiving appropriate nutritional support. Where this identified weight loss we saw evidence in people's care records that professionals such as GPs were contacted to see if additional support was needed.

The service had a cook, who worked five days a week. When they were not working care assistants were responsible for food preparation. The cook told us, "If I hadn't been in today it would have been down to the manager and [named care assistant] to do the meal. We try to do simple things that can be done quickly, like meals cooked different ways."

People spoke positively about food at the service. One person we spoke with told us, "I like whatever comes. Fish and chips Friday is my favourite. If I don't like the choice they give me something different. Yes, they are very good like that. We have some laughs as well and I get plenty of drinks." Another person said, "There is too much to eat and good choice. My favourite is breakfast." Another told us, "I've no complaints. Food is smashing, especially the cottage pie, although I take what comes and eat practically everything they bring." People ate their meals in the communal dining room. We observed people enjoying lunch, and throughout the day people had access to drinks and snacks whenever they wanted them.

Good

Is the service caring?

Our findings

People spoke positively about staff and the care they received at the service. One person said, "Yes, I am well looked after and have no complaints." Another person said, "It is really friendly and like being at home. I'm well looked after." When talking about staff, one person told us, "I have no single favourite. They are all my favourites." Another person said, "The staff are my family." Another person we spoke with told us, "I used to have carers coming into my home to help but they were useless. They were not helpful at all. It's much better here".

People told us they were treated with dignity and respect, and that staff protected their privacy. One person said, "They knock on my door." Another person told us how they liked to have the TV in the communal lounge playing loudly due to their hearing difficulties. They said this started to upset other people using the lounge, so staff suggested using subtitles so other people's privacy could be protected but the person could still enjoy their programmes.

Throughout the inspection we saw that when people indicated they wanted support, staff approached them and spoke quietly to protect their privacy. Staff also asked permission before assisting people, and explained what they were doing at every stage. People were given choices and asked for permission throughout the inspection. For example, we saw a member of staff ask a person who had difficulty walking if they could help them move from the dining table to the lounge. People confirmed they were free to make choices over how they spent their day or how they wanted to be supported. One person we spoke with told us, "I can go to bed or get up when I want."

Staff knew the people they supported well, which meant they could have interesting and meaningful conversations with them. Whenever staff introduced us to a person they were able to tell us about their background, their family and things that interested them. We also saw staff having enjoyable conversations with people about these things.

We saw numerous examples of kind and caring interactions between staff and people at the service. For example, one person was singing in a corridor and a member of staff nearby heard this and joined in. The person enjoyed this, and joked with the member of staff when they finished. We saw another person dancing in a lounge, and then asking for a member of staff to join them. The member of staff spent time dancing and talking with the person, which the person clearly enjoyed. A group of people chose to sit in the entrance corridor during our visit and jokingly said they were acting as security for the building, and staff joined in with the joke. Throughout the inspection we saw people and staff laughing and joking with one another, though staff remained professional at all times.

At the time of our inspection two people were using an advocate. Advocates help to ensure that people's views and preferences are heard. People's care records contained evidence of the involvement of their advocates in care plan reviews, which helped ensure people's views were considered in care planning.

At the time of our inspection no one at the service was receiving end of life care. However, people had a

'planning future care' care plan in place. This recorded people's wishes and preferences in relation to end of life care and included evidence of the involvement of people's families in such discussions.

Requires Improvement

Is the service responsive?

Our findings

We received mixed feedback on activities at the service. One person we spoke with said, "I just watch TV. I don't want to do any activities. Sometimes I'm taken for a walk and the vicar comes in occasionally." Another person told us, "I like drawing and watching TV but don't go out unless my family takes me." Another said, "We do singing and I like that." Another person told us, "I go to Church with a member of staff when I go out. I would love to go out more."

Staff told us they thought people would benefit from more activities. One member of staff said, "People don't have enough activities to do, though a lot of them aren't interested in doing any more than they do. But I think if people wanted to do more the resources aren't there to do it. It would be nice to take people out more." Another member of staff told us, "I think people would like more outings but we're restricted with it. If they went it would leave one member of staff. Some people don't like going out but I think others would benefit. From our meetings (feedback meetings for people living at the service) some are fine doing what they are doing. No one has actively expressed a view to go out but I think people living with a dementia would benefit (from going out)."

People were supported with activities by care staff. The manager told us, "Care assistants will do activities like chair exercises during afternoon quiet time. The difficulty is that we can have nine people wanting to do nine different things so you have to find something for everyone." They went on to tell us that if an emergency came up requiring the attention of staff then activities would not take place. If something like an emergency came up it would have to – activities – suffer." During our inspection we saw people taking part in armchair exercises and singing, with staff making an effort to spend social time with people whenever they could. However, during our inspection additional staff were working to support the manager and our judgment was staff would have had less time to spend on activities during a normal working day.

People's care plans began with their photograph and a summary of information about them, including their immediate family, their GP and any known allergies. This was followed by a 'My Life Story' document. This set out people's family history, details of their working life and their likes and dislikes. This helped staff who had not met the person before to learn about their preferences.

Before people started using the service their support needs were assessed in a number of areas, including personal hygiene, nutrition and hydration, skin integrity, mobility and falls, night care and mental. Where a support need was identified a care plan was put in place based on people's preferences. For example, we saw that one person's nutrition and hydration plan detailed the specific crockery they liked to use for eating and drinking. Another person's personal care plan detailed how they liked to check the time if they woke up during the night so reminded staff to ensure their clock was positioned near their bed. This meant people received the support they wanted.

Care plans were regularly reviewed to ensure they reflected people's current needs and preferences. Daily notes were used to record any changes in people's support needs as well as a general overview of their welfare. We saw staff discussing people's needs and preferences throughout the inspection, including at

handovers when staff changed shifts. This helped ensure staff had the latest information on people's support needs and preferences.

There was a complaints policy in place. This was given to people when they started using the service and set out how complaints would be investigated, including the details of organisations people could contact if they were dissatisfied with the response. The service had not received any complaints since our last inspection in June 2016. People told us they knew about the complaints procedure and would be confident to raise any issues they had.

Requires Improvement

Is the service well-led?

Our findings

There was a manager in place but they were not a registered manager. The manager's role had recently been changed to that of a full-time care assistant. However, as well as their new care role they were still responsible for managing the service. The manager was only able to carry out their management role in their own time. We saw from staff rotas that there was no time allocated for the manager to carry out management responsibilities. The manager told us they kept on top of these by staying back at the end of their shift and working on their own time. The manager told us, "(There is) no contracted time to do management, as if I took time out of the rota staff would be left with one staff member. [The registered provider] has said she wants me to be more of a care manager. She feels that with nine residents you don't need specialist management time." The manager also said, "If things need doing I will stay back and do it on my own time. I wouldn't let it affect the client's (people using the service) time."

The manager and registered provider carried out a range of quality assurance checks to monitor and improve standards at the service. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations. The manager's checks included auditing care plans, accidents, medicine records, the dining experience, health and safety, hand hygiene records and weights and nutrition. The registered provider carried out regular checks of the service premises and maintenance records. Where issues were identified remedial action was taken and recorded. For example, the manager's November 2016 medicine record audit identified that staff were not always recording required information. The manager spoke with staff about this and the December 2016 audit showed an improvement in recording. In another example, the registered provider's 16 January 2016 audit identified that a doorway needed cleaning and recorded that this had been done.

Staff told us they felt supported by the manager, but not always by the registered provider. One member of staff told us, "I have been happy to raise issues with both the manager and registered provider. They are both approachable. [The manager] is very approachable and I have no problems with the registered provider." Another told us, "[The manager] is really approachable so I am not shy in discussing things with them or raising issues." Another member of staff said, "We get as much support as we would want from the manager. I think she has her hands tied. (I) worry she is working herself into the ground. Couldn't ask for a better manager. Easy to talk to. [The registered provider] is not so easy to talk to. It's her way or no way." Another member of staff told us, "[The manager] is brilliant, can talk to her about anything." When we asked about communication with the registered provider, the same member of staff said, "Non-existent." Another member of staff said the registered provider told staff to leave if they were not happy at the service.

Feedback was sought from people using the service at meetings. The manager said these were informal given the size of the service, and people confirmed they were asked for feedback and would raise any issues they had. One person told us, "I used to go to meetings but don't bother now as there is nothing to complain about." The service had previously sought feedback using questionnaire sent to people and their relatives but stopped doing this when no responses were received. The manager was working on a new, dementia friendly questionnaire that they hoped to send out in 2017. The registered provider sent people a monthly

newsletter with news about the service, which also invited people to contribute and make suggestions.

The manager used staff meetings to seek feedback from staff and to discuss any support needs they had. Staff told us they found staff meetings useful.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification'. We saw from records at the service that we had not always received required notifications about safeguarding incidents. The manager had sent these to the relevant local authority, but not to CQC as required. We reminded the manager and registered provider of the requirement to submit notifications.

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 HSCA RA Regulations 2014 Staffing Staffing levels were not sufficient as too few staff were deployed to administer medicines at night, to allow staff to have proper breaks and to properly supervise people requiring two to one support. Regulation 18(1).