Essex County Care Limited

Trippier

Inspection report

22 Blackthorn Avenue
Colchester
Essex
CO4 3PU

Tel: 01206860537
Website: www.southendcare.com

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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 10 November 2016 and the inspection was unannounced. We visited again on 16 November 2016 and this inspection day was announced. During our last inspection of this service on 10 January 2014 we found that the service was compliant.

Trippier can provide accommodation and personal care for up to 36 older people, some living with dementia. At the time of our inspection there were 35 people living at the service.

There was a registered manager in post. A registered manager is a person who has registered with CQC 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.

There were not enough staff to support people safely. People told us that they felt rushed by the staff, we saw that they were on the go all day and did not have time to spend with people who told us that they spent a lot of time waiting for help. The manager was expected to spend a proportion of their work day supporting people with personal care, which had a detrimental effect on their management duties. There was no deputy manager to support the manager with their workload.

Medicines were managed and stored properly and safely so that people received them as the prescriber intended. However, the medicine records were not always audited properly making them vulnerable to going missing.

People told us that the food was well cooked and had enough to eat and drink to meet their needs. Staff assisted or prompted people with meals and fluids if they needed support. But mealtimes were not always a positive experience.

Care plans were not person centred, but staff showed an understanding to each person's preferences and needs so that they could engage meaningfully with people on an individual basis. However, the service did not have dedicated activity staff and care staff were too stretched to be able give people the opportunity to take part in activities and pastimes that were tailored to their preferences and wishes. People told us they were bored and spent days when no activities were on offer. People living with dementia, who were not being supported or engaged by staff, and spent time walking around the service, sometimes appearing concerned, trying to initiate interactions with staff and visitors.

Individual staff treated people with warmth and compassion. However, the organisation did not reflect a caring attitude by not making sure that there was enough staff on duty to ensure that they were well looked after and that staff had time to interact with people properly to keep people engaged and fulfilled. Nor did the provider offer people an environment that was clean, attractively furnished and free from unpleasant smells.

The manager displayed good leadership; we found they displayed an open and positive culture. The staff told us that the manager was supportive and easy to talk to. The manager was responsible for monitoring the quality and safety of the service and was supported by the operations manager. There were management meetings with the provider and the providers visited the service regularly the check the quality of the service. They acknowledged the shortfalls of the service, but they had had not taken action to make the necessary improvements. For example taking action to increase staffing numbers, to improve the environment or ensuring there were appropriate staff employed to offer people meaningful activities to keep people engaged with their environment.

Staff knew what to do if they suspected someone may be being abused or harmed and because they had received training to help them recognises and understand the signs of abuse. They were respectful of people's privacy and dignity.

Staff had received the training they needed to understand how to meet people's needs, including dementia training. They understood the importance of gaining consent from people before delivering their care or treatment. Where people were not able to give informed consent, staff and the manager ensured their rights were protected. Staff were clear about their roles and recruitment practices were robust in contributing to protecting people from staff who were unsuitable to work within the care profession.

Staff also made sure that people who became unwell were referred promptly to healthcare professionals for treatment and advice about their health and welfare.

Staff understood the importance of responding to and resolving concerns if they were able to do so. Staff also ensured that more serious complaints were passed on to the management team for investigation. People and their representatives told us that their complaints were addressed by the manager.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The provider had failed to maintain safety by making sure that there were enough qualified, skilled and experienced staff on duty to meet people's needs. Staff had received training in how to recognise abuse and report any concerns.

The service managed and stored medicines properly. However, the medicine records were not always audited properly making them vulnerable to going missing.

Risks to individuals were assessed and safeguards were in place. Each person had an individual care plan which identified and assessed risks to their health, welfare and safety. However, there were risks in the environment that meant that people were not always safe.

Is the service effective?

Requires Improvement

The service was always effective.

Staff understood how to provide appropriate support to meet people's health and nutritional needs. Mealtimes were not always a pleasing experience.

Staff received the training they required to provide them with the information they needed to carry out their roles and responsibilities.

The Deprivation of Liberty Safeguards (DoLS) was understood by the manager and staff. Where people lacked capacity and their freedom of movement restricted, the correct processes were in place so that decisions could be made in the person's best interests.

People were supported to maintain good health and had access to healthcare services.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff treated people well and were kind and caring in the way that they provided care and support. However, the organisation did not reflect a caring attitude by failing to ensure that staffing levels and their mix was appropriate to meet people's needs.

People were treated with respect and their privacy and dignity was maintained. .

People were supported to maintain relationships that were important to them and relatives were involved in and consulted about their family member's care and support.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's choices and preferences were not recorded and the care plans, although they contained all the necessary information were not person centred.

People's interests and hopes were not recorded and people did not have access to activities and meaningful pastimes.

There were processes in place to deal with any concerns and complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Staff told us the management were supportive and they worked well as a team. However, the providers had not taken action to maintain good practice and had not ensured they supported people to live fulfilled lives or looked after their wellbeing.

The manager had systems in place to monitor the quality of the service. However, the provider had failed to take action improve the standards when necessary.

People and their relatives were consulted on the quality of the service they received.

Trippier

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 10 November 2016 and the inspection was unannounced. We visited again on 16 November 2016 and this inspection day was announced. The inspection was carried out by one 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. Our expert had the experience of supporting an elderly relative.

Before the inspection, the manager completed 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.

Before we carried out our inspection we reviewed the information we held on the service. This would include statutory notifications that had been sent to us in the last year. This is information about important events which the provider is required to send us by law. We would use this information to plan what areas we were going to focus on during our inspection.

During our inspection we observed how the staff interacted with people who used the service and spoke with 11 people who used the service, four people's relatives, the manager, five care staff, two housekeeping staff. We spoke with two health care professional during the inspection.

We also looked at five people's care records and examined information relating to the management of the service such as health and safety records, staff recruitment files and training records, quality monitoring audits and information about complaints.

Requires Improvement

Is the service safe?

Our findings

The service was not always safe. There was not sufficient staff on duty to keep people safe and protect them from harm. Some people living at Trippier did not always feel safe living there. When we asked why one person told us "They [the staff] do a lot of rushing about, I sometimes have to wait a long time if I need help." Another person told us, "They [the staff] are always telling us they're busy, 'I can't help you now, I'm busy. I'll come back later.' You know, that sort of thing."

Some people were not able to talk to us because they were living with dementia, but we spent time with some of those people, chatting with them generally. Some were not able to relax; they gave the impression of being uneasy and worried. They were not being supported or engaged by staff, and spent time walking around the service trying to initiate interactions with staff and visitors. Staff did chat with them in passing, but were not able to stop for long and the person was left still wanting.

Staff appeared busy and were rushing to and fro most of the time throughout the days of our inspection. One person told us, "Don't bother with the buzzer. I tried it once waited over 30mins for someone to come. It's a worry, if I was ill or hurt, how long would it take them to help me?" And another person said, "Staff do their best, but they seem to come and go." Also, another person told us that they did not think there were sufficient staff, "… especially at night."

Staff told us that they were kept busy, felt rushed and did not think they were able to give people the time they needed during personal care. Nor did they have time with people to, "Just spend the time of day with the residents and chat about their lives… Sometimes even the residents are telling us to slow down a bit!"

The manager told us that they regularly used the provider's needs assessment to calculate the necessary staffing levels. However, the assessments we looked at did not reflect the people we saw. Four person were on their feet, walking around the building, going from room to room and, on occasion, getting moved on by other people who did not want them in the lounge they were in because they disturbed them by touching their possessions or sitting by them and trying to engage them in conversation. These people were not always steady on their feet; one had a frame but did not always use it. Another person could not find a hankie and used their top to wipe their nose and completely exposed their upper body. Their needs assessments placed them as having a low needs level and did not recognise that they needed extra supervision to, keep them safe, attend to their social needs and protect their dignity. This indicated that people's care needs were not properly being calculated, meaning that the staffing levels suggested by the

The manager told us that they had several vacancies due to several staff leaving over a short period and that they were having problems recruiting to those posts and when they did there was a high staff turnover. There was also a high level of sickness in the service. This had caused problems in staffing the service appropriate levels. The past rotas that we looked at did show shortfalls on some of the shifts.

The manager was expected to work 40% of their hours working on shift supporting people with personal care. The rota showed that they did extra hours on top of their contracted hours to cover shifts that were

short because of sickness or annual leave. They routinely started shift at 7am and assisted with getting people up in the mornings and would continue helping until people were up. With only 60% of their time as supernumerary and much of that percentage being eaten into by them having to do extra care hours, this had a detrimental effect on their management duties. The service would benefit from having a deputy manager who would assist the manager in their role and be available to help step in when there is a care staff crisis.

The service did not have an activities coordinator, the expectation was that the care staff would provide the people who used the service with meaningful activities to keep their minds engaged and help to maintain people's wellbeing. People and their families told us that they were not offered activities on a regular basis and the staff told us that they did not have time to offer people support with activities.

There was not always sufficient staff on duty to care for people when they wanted or needed it or to help keep people safe. This is a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw there was a recruitment and selection policy in place. The registered manager told us as part of the recruitment process they obtained two references and carried out Disclosure and Barring Service (DBS) checks for all staff before they commenced work. These checks identified whether staff had any convictions or cautions which may have prevented them from working with vulnerable people. We saw there was a staff disciplinary procedure in place to ensure where poor practice was identified it was dealt with appropriately. The manager told us if they found a member of staff was no longer suitable to work in a health or social care setting they would make a referral to the appropriate agency, for example, the Disclosure and Barring Service. The employment files we looked at showed that all the appropriate checks had been made prior to employment.

Medicines, including controlled drugs, were not always managed safely by the service. We observed staff administering medicines to people and saw that they did it in a patient and caring manner. They offered a person their as and when required (PRN) pain relief medicine in a kind and appropriate manner, "Are you in pain? Do you need pain relief?" Where people needed PRN there were protocols in place to inform staff when to use them.

In the recent past medicines had gone missing from the service unaccountability and safeguards had been set up to avoid this happening again. It was expected that senior staff carried out daily audits of the medicines to ensure that all of the medicines accounted for and so that a discrepancies could be addressed quickly. However, within days of our inspection we were notified that some controlled drugs had gone missing. During the investigation it was established that, although the seniors on duty prior to the medicine being found to be missing had signed the audit chart to say they had checked and counted the medicine and found it to be in order, they had not. They had just signed the record sheet without counting the medicines. This led to the actual time the medicines went missing could not be identified, which hampered the investigation. Therefore where they had gone or who had taken them could not be found out.

The service had not properly ensured that the medicines were kept safe and did not go missing. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we saw that the furniture was warn and is some cases torn and unhygienic. Several of the sofas and chairs were urine stained and smelt unpleasant. Some were also torn with the foam cushions inside and the inner upholstery being exposed. Not only did they smell unpleasant they were unsightly, not welcoming and uncomfortable to use. The provider had acknowledged this and had said in a managers

meeting that they, 'Will be looking to invest more money into the Essex Homes in 2017,' But no time scales were set and the condition of some of the furniture in this service is unhygienic and was in need of immediate replacement.

The condition of some of the furniture meant that it could not be kept hygienic and would expose people using them to the risk of infection. This is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff told us they had received training in protecting adults from abuse and how to raise concerns. They understood the different types of abuse and knew how to recognise them. Staff were able to tell us what action they would take if any form of abuse was suspected, they were clear who they would go to internally and also said they would go to the local authority safeguarding team if they needed to report a concern externally. Information was on display from the local authority detailing how to report a concern.

One member of staff said, "I would have no hesitation in going to [the manager]." And another said, "I wouldn't stand for that at all, I'd get it reported straight away." Staff were also aware of the whistleblowing policy and said they felt that they would be supported and protected if they used the process. Staff told us that they had confidence that any concerns they raised would be taken seriously and action taken by the manager.

The manager demonstrated an understanding of keeping people safe. Where concerns had been raised, we saw that they had taken appropriate action liaising with the local authority to ensure the safety and welfare of the people involved.

Risk assessments were in place that were designed to minimise the risk to people in their day to day lives so that they could keep their independence and self-determination as much as possible. For example the risk of falling, there was guidance for staff on what support people required to reduce the risk.

There were also policies and procedures in place to manage risks to the service of untoward events or emergencies. For example fire drills were carried out so that staff understood how to respond in the event of a fire. Fire fighting equipment was available and emergency lighting was in place. We saw fire escapes were unobstructed.

All hot water taps were protected by thermostatic mixer valves to protect people from the risks associated with very hot water. Heating to the home was provided by radiators and all of them were covered to protect people from the risk of being burnt burn from the hot surface.

Requires Improvement

Is the service effective?

Our findings

The service was not always effective. We asked people using the service and their relatives if they felt that their needs were being met by staff who knew what they were doing. People told us that staff worked hard to make sure that they got what they needed. One person said, "I get what I need, it may take a while but they [the staff] get there." Another person told us, "They [the staff] know what they're doing, they are good people."

We observed lunch on two occasions, there was one main dining room and people can also chose to eat in their own bedroom. The mealtime experience in the dining room appeared to be a rather long and uncomfortable time for some people. People were started to be collected in the dining room half an hour before the meal was due to be served. Once people were assembled, staff collected meals for people in their bedrooms from the serving hatch and left the dining room. Meaning that staff left in the dining room were stretched, for several minutes at a time there were no staff, apart from the kitchen assistant present in the dining room. This left people at risk because there would be no help if people had trouble with their food, if anyone choked for example.

Those people who did not need support were given their meal and then were left to their own devices. Those people who needed support to eat were left until the staff who had been supporting people in their bedrooms had returned to the dining room. This meant that the people who needed support had to wait a long time for their meal. People got impatient and one person kept walking out of the dining room, they were bought back and sat down at a table again by staff, but as soon as the staff had left the room they got up and walked off again. With no-one available to supervise, it was uncertain that they would have had sufficient food.

Drinks were available at all tables and staff did ensure that all diners had a drink. However, once again the lack of supervision meant that not all diners actually took in fluids at lunchtime. Because there were not enough staff in the dining room to encourage and support them to eat, people's meals got cold and were not eaten. Once the meal was finished, it took a long time for staff to help people return to the lounges, some people got impatient and shouted out for help. One person put their head on the table and held it in their hands between calls for help.

Menus offered a choice of two meals. The food was served to everyone individually on warm plates and looked appetising. One person told us that, "Today was very good, yesterday the chicken was cold, though it wasn't supposed to be." Another person said "The food's very good, but there is always a lot of hanging around." A third person told us "It's very good. There's always a choice and if I don't like something they will always find me an alternative."

Plate guards and specialist utensils were available for those who found it easier to eat with these aids. This helped to promote independence, meaning that people could manage to help themselves to eat without the need of staff support.

The home had responded to specialist feedback given to them in regard to people's dietary needs and had taken action to meet them. For example, by introducing food that was fortified with cream and extra calories to enable people to maintain a healthy weight. People's weights were monitored so that staff could take action if needed. For example, they would increase the calorific content in food and drinks for those people losing weight or refer them to the dietician for specialist advice.

Care and kitchen staff were found to be knowledgeable about supporting people to eat healthily and meeting their individually assessed dietary needs.

Records showed that staff received training and support to enable them to do their jobs effectively. Staff told us they were provided with training and support which gave them the skills, knowledge and confidence to carry out their duties and responsibilities. Some told us that their one to one supervisions did not happen as often as they had been lead to believe they would be, but that they knew the manager was kept busy and were able to talk to them to discuss concerns or to clarify issues and still felt supported. Following inspection we were sent evidence that showed staff supervisions took place every two months in line with organisational policy.

The manager told us that the care staff were supported to gain industry recognised qualifications in care, an National Vocational Qualification (NVQ) in care or more recently a Qualifications and Credit Framework (QCF) award. This meant people were cared for by skilled staff, trained to meet their care needs.

We found staff to be knowledgeable and skilled in their role. Staff told us that they underwent a full program of training, one said, "We're trained to take care of these people as we would our own gran, that's as it should be."

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 MCA. The authorisation 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. The manager understood both the MCA and DoLS and when these should be applied to the people who lived in the service, including how to consider their capacity to make decisions. They told us that they had made applications for authorisation to deprive some people living in the service of their liberty in order to keep them safe, which assured us that they had taken action to comply with the March 2014 Cheshire West Supreme Court judgement that had widened and clarified the definition of deprivation of liberty.

People's individual records included an assessment of capacity and consent to care and treatment forms. People had their capacity assessed and staff supported people to make their own decisions and keep control of their lives. A staff member told us, "it's not up to me to tell people what they should do."

One person told us, "They [the staff] let me decide if and when I have a bath." A relative told us "[My relative] makes [their] own decisions and the girls [staff] respect that."

People's care records showed that their day to day health needs were being met and that they had access to healthcare professionals according to their specific needs. Records showed that people were supported to attend hospital and other healthcare professionals away from the service. For example, specialist diabetic clinics and diagnostic tests. One person said, "I see a doctor if I need to." Another told us, "They know if I'm not well and get help."

One person who was living with a hearing restriction had regular visits from a person from the Royal Association for the Deaf. They visited each week, as part of their visitor role they ensured the person's needs were met and communicated those with the staff. They said that the person they visited told them that they were well treated and cared for. There were communication difficulties but a number of the staff had endeavoured to learn at least some basis sign language and this had been useful.

A healthcare professional, working at a local hospice, told us that they and the manager were working together to help people plan for their end of life care. They said that the manager was, "A strong advocate for people," And said they had seen some good, positive end of life care within the service.

Requires Improvement

Is the service caring?

Our findings

People told us that overall the staff showed a caring attitude towards them. One person told us, "They [the staff] are good people and try hard to help us, but they are rushed at times." Another told us, "The staff are kind and care what happens to me, I wish they had more time to stop and chat."

Interactions between staff and people who used the service were caring and appropriate to the situation. Staff demonstrated an understanding of how to meet people's needs. They spoke about people respectfully and behaved with empathy towards people. People's needs and preferences were understood, but the atmosphere was sometimes strained because the staff were busy and unable to spend as much time with people as people wanted with them. People living with dementia walked around the service constantly and caused friction between people because there was not enough staff supervision to help them stay busy and distract them from interfering with other people and their belongings.

One person told us, "Staff do their best, but I'm not sure there are enough of them." Another said, "They [the staff] are nice but few.

It was obvious that the staff were caring, supportive and had built close relationships with the people they cared for. However, the organisation did not reflect a caring attitude by not making sure that there was enough staff on duty to ensure that people were well looked after and that staff had time to interact with people properly to keep them engaged and fulfilled. Nor did the provider offer people an environment that was clean, attractively furnished and free from unpleasant smells.

The manager assured us that people were encouraged to be involved in planning their care where they were able. But was not obvious in the care plans that people had been involved in reviewing their care plans, people had not signed their care plans to indicated they had been involved. One person told us, "They asked my about what I like and don't like and they wrote it all down." A relative told us they were included in discussions about their family member's care and were kept up to date. "We talked about [my relative], about what they were like before they came here."

People were treated with dignity and respect and staff were discreet when asking people if they needed support with personal care. One person told us, "They [the staff] try to make sure I don't get embarrassed, that's important to me." Another said, "They [the staff] check I'm alright, they're so kind." Any personal care was provided in private to maintain the person's dignity. We observed staff knocking on people's doors and waiting to be invited in before entering. Doors were closed during personal care tasks to protect people's dignity and we observed staff discreetly and sensitively asking people if they wished to use the toilet.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive to people's needs. Relatives told us that overall the standard of care their family members received was alright, but some felt it did not met their individual needs. One relative told us that their relative was, "Fed and watered and clean, but they sit around all day watching TV and hardly talks to anyone." Another relative said, "Staff seem focussed on getting the day to day tasks done." One person said, "The girls [staff] are lovely, but you get rushed up and then do nothing all day."

People and relatives told us that they had been provided with the information they needed during the assessment of need process before they moved in. Care plans were developed from those assessments and recorded information about the person's care needs.

Care plans were detailed enough for the carer to understand how to deliver care to people in a way that met their care needs, but were not holistic or person centred. The outcomes for people included supporting and encouraging people to stay independent in areas where they were able to be, such as in choosing their own clothes to wear and maintaining personal care. One person said, "I do what I can and they [the staff] help when I need it."

However, care plans did not always record people's individual interests and people's preferences were not asked. We found that many of the areas of the care plans that were meant to capture the person's individuality and past life histories were either not completed or held minimal information.

People told us that they did not get many opportunities to follow their interests or to take part in meaningful activities. One person said, "It can get very boring, I'd like the chance to have a go at different things, but there is nothing to do." We saw that some people found it frustrating when people living with dementia tried to take their belongings and became argumentative or disruptive. Throughout our inspection we saw that three, and sometimes four or five, people paced from room to room, walking up and down the corridor stopping people, asking for help or direction. One person said, "I try to read but those [people] come in and won't leave me in peace. I know it's not their fault but I'd like some peace."

Staff had received specialist dementia training, including a session where they were able to experience what living with dementia was like through an interactive session. However, due to lack of time the care staff were not able to use their knowledge in trying to engage with people living with dementia and finding ways to help them feel relaxed and engaged in the service.

The service did not have a dedicated activities coordinator and with the staff being under pressure to get their tasks done due to staff shortages, there were few planned activities, outings and entertainment offered to people. The care staff were expected to run activities with people and did when time allowed. One staff member told us, "We have regular bingo sessions and, especially at Christmas, some craft based activities, we'll be making Christmas cards and decorations." However, there was little evidence of any activity during our inspection, people were either sat in the lounge or pacing round the corridors. We saw that some people spent long periods asleep in the lounges.

The activities that people were offered were recorded in their care records. One person's was recorded as 31/10/16 Halloween Party –declined, 2/11/16 Bingo – declined, 4/11/16 hairdresser – declined, 5/11/16 one-to-one session – happy, 8/11/16 Singer – enjoyed, 10/11/16 Relaxing in bed. 11/11/16 hairdresser – declined. Another person's records for the same period recorded their activities as relaxing in the lounge, One to One - Not happy, Singer – enjoyed. There was no evidence that any action had been taken to find out why the person had said they were unhappy during their one to one session or to find ways to make them feel happier. People having their hair done, relaxing in bed and relaxing in the lounge are not activities and should not be considered as such.

The service did not offer people meaningful activities to keep them entertained and their minds engaged. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People were supported to keep in touch with others that were important to them such as family and friends, so that they could maintain relationships and avoid social isolation. When asked about visiting times a relative told us, "I come and go as I please and there is no fuss if I want to take [my relative out." Input from families was encouraged and relatives told us they were always made welcome when they visited.

The provider had a procedure in place to manage any concerns or complaints that were raised by people or their relatives. The organisation's complaints procedure was displayed openly throughout the service and we saw that complaints were recorded in line with these procedures. The manager said that they encouraged people to raise concerns at an early stage so that they could learn from them and improve the service.

People told us that they if they had concerns or a complaint, they knew what to do and who to talk to. One person said, "When I made a complaint, they [the staff] helped me as best they could." A relative told us "If I'm worried I speak to the manager and it's dealt with."

Requires Improvement

Is the service well-led?

Our findings

The service is not always well led. Relatives told us that the manager was approachable and made themselves available if they wanted to speak to them. Staff told us they felt supported by the manager and could approach them at any time. One relative told us, "Over the last few months things have gone downhill a bit, a lot of good staff have left and there's been problems getting the new ones to stay." A professional healthcare visitor told us that the home was well managed and that all the staff communicated effectively with their service.

There were systems in place to monitor the quality and safety of the service. The manager carried out regular audits which were submitted to the provider. This included audits of staff training, health and safety procedures and a general building audit.

There were also management meetings with the provider and the providers visited the service regularly the check the quality of the service. They acknowledged the shortfalls of the service, but they had had not taken action to make the necessary improvements. For example taking action to improve the environment, to increase staffing numbers and ensuring there were appropriate staff employed to offer people meaningful activities to keep people engaged with their environment.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that the manager had a good rapport with all the staff. We observed them talking to staff members and relatives, they listened and gave good eye contact. The manager was knowledgeable about the people living in the service, by working alongside the care staff in offering people personal care, it meant that they were in daily contact with people and monitored staff and the delivery of care closely.

All the staff we spoke with told us they felt supported by the manager and were positive about the way they managed service and told us that they felt they could approach the manager if they had any problems.

People were given the opportunity to tell the provider what they thought about the service they received. People and their families were asked their views about the way the home was run through completing annual surveys. The manager told us that they were in the process of sending out surveys for 2016.

We saw from the records that people were protected because health and safety checks such as fire drills and essential maintenance checks, the lift and hoists were up to date and regularly scheduled.

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 9 HSCA RA Regulations 2014 Person-centred care The service did not offer people meaningful activities to keep them entertained and their minds engaged.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service had not properly ensured that the medicines were kept safe and did not go missing.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The condition of some of the furniture meant that it could not be kept hygienic and would expose people using them to the risk of infection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service did not have an effective quality assurance monitoring process in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care

There was not always enough staff on duty to care for people when they wanted or needed it or to help keep people safe.