Pressbeau Limited

Tithe Farm Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Inadequate**
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

Tithe Farm Nursing Home is registered to provide accommodation and nursing care for up to 35 older people. On the day of our visit there were 28 people using the service.

The registered manager has been in post since July 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People spoke positively about the care they received. One person commented, "I like them (care workers) they do a great deal for us and they never query what I want, and they are so polite." We saw one care worker made good eye contact with a person, stroking their hair gently and speaking to them in an affectionate manner.

Reviews of care were not consistently undertaken. Some care records showed when people and their relatives met to review the care being delivered whilst other care records showed no evidence that this had occurred.

Summary of findings

The service did not capture people's preferences in regards to end of life care. Where people received end of life care, there was no care plan put in place and staff had not undertaken the relevant training.

Most people said they felt safe and were never shouted at or abused. One person commented, "I feel safe my daughter put me in here because I was falling all the time." Another person said they felt safe in the environment but went on to say, "Some of the staff are a bit rough and I have had a bruise or two." We found where people sustained unexplainable injuries, no action was taken by the service to investigate or escalate them to the appropriate agencies. This placed people at risk of unsafe care and inappropriate care.

Health and safety audits undertaken were not able to identify safety risks for example, fire doors not opening or jammed and the stair gate being left opened by staff. There were no systems in place to mitigate identified risks relating to people's health. For instance, no risk assessments were put in place for people assessed with identifiable risks. This placed people at risk of unsafe and inappropriate care.

The staff dependency assessment tool used to ensure there was enough staff to meet people's needs, did not accurately reflect the dependency needs of people. During the first of day of our visit we observed staff were rushed; task focused and had little time to interact with people. One staff member told us they had to work through their morning break due to the workload. We found there were not sufficient numbers of staff deployed to meet people's care and treatment needs.

Necessary recruitment processes and checks were in place and being followed. People received support from staff with their medicines to ensure they were managed safely.

People were not always supported by staff who received appropriate induction, training and supervision.

People spoke positively about the food. For instance, one person commented, "The dinners are very nice and if you want anything different they will cook it for you." Some people were able to eat and drink independently however; we found a lack of staff impacted on how other people were supported during mealtimes.

Where restrictions were put in place in order to keep people safe, best interest meetings records evidenced discussions were held with people; their representatives; staff and relevant health care professionals. We saw the least restrictive options were considered.

We did not however, see documentary evidence to show what legal powers people's representatives had. This meant there was a possibility the service obtained consent from people who did not have the legal power to give it. We recommend the service finds out more about obtaining consent, based upon current practice, in relation to the MCA.

The home had recently been refurbished and the floors had been laid with wood laminate which made it much easier for people who use wheelchairs and walking frames to get about. The director told us special lights had been installed which were designed to help people who had dementia. We saw no memory boxes or personalised signs to help people with cognitive impairments to orientate them around the home.

People's social needs were not being met. People told us they were bored and activities did not occur regularly.

People and their relatives said they knew how to make a complaint. One person said they knew how to raise a complaint and thought staff listened to them.

Quality assurance systems were in place was not effective in assessing, monitoring and improving the quality and safety of services provided.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We are taking enforcement action. 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?

Inadequate

Where people sustained unexplainable injuries, no action was taken by the service to investigate or escalate them to the appropriate agencies.

Health and safety audits undertaken were not able to identify safety risks.

We found there were not sufficient numbers of staff deployed to meet people's care and treatment needs.

Is the service effective?

Requires improvement

People were not always supported by staff who received appropriate induction, training and supervision.

Some people were able to eat and drink independently however; we found a lack of staff impacted on how other people were supported during mealtimes.

People and their relatives said they knew how to make a complaint. One person said they knew how to raise a complaint and thought staff listened.

Is the service caring?

Requires improvement

The service was caring.

People spoke positively about the care they received.

We saw one care worker made good eye contact with a person, stroking their hair gently and speaking to them in an affectionate manner.

The service did not capture people's preferences in regards to end of life care . Where people received end of life care, there was no care plan put in place.

Is the service responsive?

Requires improvement

Reviews of care were not consistently undertaken.

People's social need were not met.

People and their relatives said they knew how to make a complaint.

Is the service well-led?

Requires improvement

The service was not well-led.

Quality assurance systems in place were not effective in assessing, monitoring and improving the quality and safety of services provided.

Tithe Farm Nursing 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 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 was an unannounced inspection which took place on 5, 6 and 9 October 2015. The inspection team consisted of two inspectors and an expert by experience that had personal experience of caring for someone who uses this type of care service.

Before the inspection we reviewed all the information we held about the service. We looked at notifications the provider was legally required to send us. Notifications are information about certain incidents, events and changes that affect a service or the people using it.

The provider did not complete a Provider Information Return (PIR) as this was not requested prior to the inspection. 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 received feedback about the service from a local authority officer.

We observed how staff interacted with people. Due to health reasons most of the people in the home were unable to speak with us however, we spoke with four people; two relatives; four staff members; deputy manager; registered manager and the director. We looked at 15 care records; four staff records and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People said they felt safe and were never shouted at or abused. Family members felt their relatives were being cared for in a safe way. One person commented, "I feel safe my daughter put me in here because I was falling all the time." Another person said they felt safe in the environment but commented, "Some of the staff are a bit rough and I have had a bruise or two." The person stated this happened when staff were undressing them. We immediately informed the registered manager and asked them to a raise a safeguarding alert with the local authority. We received confirmation on day two of our visit that the safeguarding alert had been raised.

Body maps were in place for people living in the service. These were used by staff to record any observable body injuries that may appear on a person's body. All of the body maps reviewed showed where unexplainable bruises were found. There was no evidence of action taken and if the appropriate agencies were notified. For example, we noted one person had multiple bruises on their left forearm since admission but there was no evidence of action taken. We spoke with the deputy manager to find out if actions taken would have been recorded somewhere else other than the care plans. The deputy manager confirmed no follow up actions were undertaken. This was not in line with the service's safeguarding policy which stated 'investigations should be undertaken when unexplained injuries occurred.' This placed people who used the service at risk of harm or unsafe care because no preventative action was taken by the service when unexplained injuries were found.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessments had been carried out to identify risks in people's health and care needs. This included risks of falls; pressure ulcers; and malnutrition. We noted the 'risk assessment' field on the electronic care plan system was blank on all care records reviewed. Care plans did not show how assessed risks were being managed. For example, one person had been assessed as high risk for pressure ulcers. Their body map had noted two more pressure ulcers had developed on 4 November 2015. Their care plan had not been updated to reflect these developments and there was no risk management plan in place to advise staff on what further action should be taken to reduce the risk. Another person had been assessed as high risk for falls. There was no evidence to show what measures had been taken to reduce the risk every time the person had fallen. On the third day of visit we heard the person had fallen and was subsequently hospitalised. Management confirmed no one in the home had a risk management plan in place. This meant people were placed at risk of unsafe or inappropriate care.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

By the end of our visit the provider had developed 10 risk management plans and confirmed after our visit that, all people with identified risks had risk management plans in place.

The staff dependency assessment tool used to ensure there was enough staff to meet people's needs did not accurately reflect the dependency needs of people. Where people were assessed as having medium or low dependency needs, their care records stated their dependency needs were high. This was evident in five care records reviewed. We noted the staff dependency tool was last reviewed on 30 October 2015. The staff rotas showed even with agency staff cover, there was still a number of days when there was not sufficient staff on duty to meet people's care and support needs.

One relative commented, "I can't tell you if there is enough staff but X tells me there's not enough." Some staff felt there were enough staff to provide care and support to people however, this was not supported by our observations. During the first of day of our visit we observed staff were rushed and task focused and had little time to interact with people. One staff member told us they had to work through their morning break due to the workload. Another staff member felt there was not enough staff to meet people's care needs. Whilst another staff member said it could take a while for care tasks to be carried out as some people exhibited behaviour that challenged. This impacted upon the care provided to people as care workers had little time to ensure their care needs were met. We found there were not sufficient numbers of staff deployed to meet people's care and treatment needs.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

On day one of our visit we observed a sliding gate at the top of the main stairs was constantly being left ajar. It was quite possible for people to go to lean against it and topple down the stairs. We brought this immediately to the attention of the registered manager who stated this would be addressed. On the second day of our visit we spoke with the director who advised us the gate required a part. The director said the part would be ordered and the necessary work would be completed as soon as possible. During our inspection we observed no interim measures were taken to minimise the risk identified. This had the potential of placing people at risk of serious injury.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed a fluid thickener was left opened in one person's room for a significant period of time. This had the potential of causing harm to people if taken inappropriately. We spoke with the registered manager who said this would be addressed. Later on that day we noted the thickener had been removed from the person's room.

Individual emergency evacuation plans were in place for people who lived in the home. This ensured people would be appropriately evacuated in the event of an emergency. We noted one person did not have an individual emergency plan in place. This was brought to the attention of the manager.

During our tour of the building we asked a member of staff to open two fire emergency exit doors situated on the first floor. The staff member was unable to open the first fire emergency exit door. Despite several attempts the staff member was unable to open the second fire emergency exit door. We brought this to the attention of the registered manager who tried and eventually opened the first emergency exit door. The registered manager struggled to open the second fire emergency exit door but eventually managed to push it open. They told us the doors were about to have electronic key pads fitted. This meant people were not protected against the risk of harm as the service did not ensure the fire doors was properly maintained and used correctly.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff said they would report their concerns to the nurse in charge or the manager, if they suspected abuse had occurred. This was in line with the service's safeguarding policy.

Necessary recruitment processes and checks were in place and being followed. Staff records included evidence of pre-employment checks including Disclosure and Barring Service (DBS) checks. These ensured staff employed was suitable to provide care and support to people who used the service.

People received support from staff with their medicines to ensure they were managed safely. Medicine and medicine administration records (MAR) were found to be correct and in order on the day of our visit. Some people were given their medicines covertly; due to having difficulty in swallowing tablets. This was in line with the correct procedure of gaining their agreement and advice from the GP and the pharmacist.

We entered the downstairs sluice room. This is a room where used disposables such a incontinence pads and bed pans are dealt with and reusable items are cleaned and disinfected. We saw uncleaned bed pans lying on the floor. We brought this immediately to the attention of the registered manager. We noted immediate action was taken as the bed pans had been cleaned and removed when we checked the sluice room within a short period of time.

Requires improvement

Is the service effective?

Our findings

People were not always supported by staff who received appropriate induction, training and supervision. Staff files showed induction was undertaken by the staff we spoke with. Staff told us it helped them to understand people's needs. We noted the service made use of agency staff on a regular basis however, there was no formal induction put in place for them. For example, we observed an agency staff member who had not worked at the home before was not given an induction to orientate them of the home, its systems and the care needs of people they were allocated to work with. The registered manager confirmed the home did not have an induction programme for agency staff. This meant people could not be confident they were being cared for by staff who were prepared for the job role they were expected to do.

Staff spoke positively about their training. We heard comments such as, "My training needs are being met", "I wanted to know more about dementia and the home organised more training on dementia" and "The training is effective. I didn't have training like this where I come from." Most of the staff we spoke with had received appropriate training; a review of their training records confirmed this.

We noted however, the staff training matrix showed there was still a number of staff who had not completed their essential training. A list of staff who had not fully completed their training and the dates they were to be completed by was displayed on the staff notice board. The list did not accurately capture all the staff whose training was not complete. There was no evidence of what action the registered manager had taken to ensure training was completed within the set timeframes.

A local authority officer expressed concerns as the registered manager had recently declined offers on training tailored for staff from the Local Authority's Quality Care Team.

Staff said they received supervision and felt supported by the registered manager. The registered manager told us supervision meetings took place every six to eight weeks. This was not supported by supervision records and the supervision matrix reviewed. For example, one staff member was last supervised in July 2015; four staff members were last supervised in June 2015. Where supervisions took place there was no clear evidence to show how staff's on-going competence was being maintained. For example, there was no evidence of what support was given to staff to ensure their essential training was completed within the set timeframes.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People spoke positively about the food. For instance, one person commented, "The dinners are very nice and if you want anything different they will cook it for you." Another person told us, "The food was not bad" and went on to say it was difficult for them to compare it with home cooked food. Care records contained people's nutritional needs; what their food preferences were and what support they required.

Our observation of the lunch time period showed staff appeared to be rushed and had little time to positively interact with people. For instance, whilst in the main dining room we saw only the registered manager and another care staff available to support people. Some people were able to eat and drink independently however; we found a lack of staff impacted on how other people who required support with their meals. For instance, we observed the registered manager had attempted to assist a person with their meal but was disturbed because they had to answer the telephone. Upon their return the registered manager went to serve two people with their deserts before continuing to assist the first person with their meal. By this time the person's food was cold and they refused to eat it. No offer was made to re-heat their food or give them an alternative meal. This meant people could not confident they would get the necessary support to eat and drink.

This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Nutritional care plans were in place and captured people's dietary needs. The chef demonstrated a good knowledge of how to ensure people received balanced meals. They knew people's dietary preferences and whether they had any allergies. We noted the chef had not completed their essential training since joining the service in June 2015.

During the breakfast period, drinks were made available to people. We heard care workers checking with each other, "Have you done this?" and "Don't worry, I will do it now."

Requires improvement

Is the service effective?

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a lawful way to deprive someone of their liberty, provided it is in their own best interest or it is necessary to keep them from harm. We saw the service had made appropriate DoLS applications to the supervisory body for people who lived in the home.

Where restrictions were put in place in order to keep people safe, best interest meetings records evidenced discussions were held with people; their representatives; staff and relevant health care professionals. We saw the least restrictive options were considered.

Staff we spoke with were aware of the implication for their care practice in regards to the Mental Capacity Act 2005 (MCA). This is important legislation which establishes people's right to take decisions over their own lives whenever possible and to be included in such decisions at all times. Staff demonstrated a good understanding of the Act and knew whether people had the capacity to make informed decisions and if not, what practices and procedures they should follow. We noted not all staff had completed the relevant training.

Where people were not able to make specific decisions, care records indicated who had legal powers to make important decisions on their behalf. We did not however see documentary evidence to show what legal powers people's representatives had. This meant there was a possibility the service obtained consent from people who did not have the legal power to give it.

There was evidence of consent being sought. For instance, we saw people or those who represented them had given consent for their photographs to be placed in their care records.

After our visit, the registered manager informed us they were in the process of getting people's representative to give them copies of documents which confirmed what legal powers they had.

Changes to people's care needs were not always kept up to date. For example, during our inspection we observed a person who, due to having pressure ulcers had to be re-positioned by staff every two hours. We noted the person's pressure ulcer care records was last updated on 25 October 2015 and failed to reflect the person had developed further pressure ulcers since that date.

The person's daily records stated the person had been moved at a particular time in the morning. However, we had visited the person several times during the morning and saw they were in the same position. We spoke with the registered manager, who stated they would look into this. On day two of our visit, we spoke with the deputy manager and the staff member who had recorded they had carried out this task the previous day. The staff member informed us they had difficulties re-positioning the person as moving them caused discomfort and therefore the person was slightly moved rather than fully re-positioned. We found the pressure ulcer care record did not make staff members aware of the additional pressure ulcers and give up to date guidance on how to manage the person's care.

People were supported to access healthcare services. This was evidenced in care records which showed people were being supported by health care professionals such as, GPs; dieticians; and social workers. During our visits we saw a number of health professionals attended the home in order to meet people's health needs.

The home had recently been refurbished and the floors had been laid with wood laminate which made it much easier people who use wheelchairs and walking frames to get about. The director told us as part of the refurbishment the corridors had been fitted with seasonal affective disorder (SAD) lights. These lights reduced low mood in the winter months for people, including those who had dementia. We saw no memory boxes or signs to help people with cognitive impairments to orientate them around the home. We were told new names plates had been ordered for the doors since some people could not remember their room. We saw one person with a walking frame stopped in the communal area and say, "I don't know where I am." A care worker came to their assistance.

We recommend the service finds out more about obtaining consent, based upon current practice, in relation to the MCA.

Requires improvement

Is the service caring?

Our findings

Although the service had procedures in place to capture people's preferences in regards to end of life care this was not always evidenced in care records. One relative told us the service had not discussed what their family member's views was on end of life care. They commented, "I know what's X's preference are in regards to end of life but this conversation has not been brought up by the home."

End of life care was being delivered to one person. A review of the person's care records showed no end of life care plan was in place. Staff training records showed staff had not been trained on end of life care. This meant people could not be confident in the service's ability to meet their end of life care needs and staff's competence to carry out this task. We brought this immediately to the attention of the registered manager.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People spoke positively about the care they received. One person commented, "I like them (care workers) they do a great deal for us and they never query what I want, and they are so polite." Another person said, "The carers look after me the way that I want. They will do anything I want and they always come in and have a chat." Other people told us care staff were nice to them and looked after them well. This was supported by one relative who commented, "Staff seem very caring gentle and respectful. There's a couple of staff who X thinks are wonderful." Another relative commented, "From what I've seen, I think the care received is very good."

During the breakfast period we heard staff address people in a polite and respectful manner. We saw a care worker made good eye contact with a person, stroking their hair gently and speaking to them in an affectionate manner.

People's need for privacy was respected by staff. Staff gave us examples of how they did this. We heard comments such as, "We ensure doors are closed when people are in the toilet and ask for permission to enter when they have finished" and "I ensure people are covered when giving them a bed bath." We noted not all staff understood how to treat people in a dignified manner. For instance, we observed one staff member supporting a person with their meal whilst standing up.

People and their relatives said they attended meetings which enabled them to give their views about the care received. One relative commented, "We attended a relatives' meeting last week. It gave us a chance to talk and air our views." One person commented, "I express my opinions no matter what anyone thinks."

People told us there were no restrictions for when relatives and friends could visit them.

People's independence was promoted and staff supported them to exercise choice. Staff told us people had the choice to eat the foods they liked and wear the clothes they wanted to. This was supported by our observations, where staff visited people's room with the daily menu to gather people's meal choices for the next day. People we spoke with confirmed they were able to exercise choice. For instance, we saw some people preferred to have their meals in the lounge rather than the main dining room.

People with spiritual needs were supported. Staff told us about one person who due to their religion did not eat certain foods. The service ensured the person received food that was prepared in line with the person's religious belief. We also observed people taking part in a church service that took place in the home. This showed people's needs in respect of their spirituality was understood by staff in a caring way.

Requires improvement

Is the service responsive?

Our findings

People told us they were bored and activities did not occur regularly. One person said they were occasions when they was singing but they found it difficult to say what else was on. They commented, "Well I do get a bit bored." This was supported by another person who said entertainers did visit the home but they could not tell us how often or when they last visited.

People's social needs were not being met. The registered manger informed us the activity co-ordinator had left the service two weeks before our visit. Although the registered manager was currently in the process of recruiting another activity co-ordinator, during our visits we saw no interim measures was put in place to ensure people's social needs were being regularly met. We observed only one activity had taken place, a church service. There were no other activities in place to stimulate people and staff was busily engaged in care tasks and had little time to positively interact with people.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans developed were not person centred as they failed to capture people's life stories. We found care workers had good working relationships with people and their relatives and held quite a lot of knowledge about people's family background. For instance, staff told us about people's work histories and how that manifested in the way they behaved within the home. We found this was not reflected in any of the care plans reviewed. This would have enabled all staff to gain an all-round picture of the people they cared for and ensure people were provided with person centred care, treatment and support.

Reviews of care were not consistently undertaken. Some care records showed when people and their relatives met to review the care being delivered, whilst other care records showed no evidenced that this had occurred.

People and their relatives said staff were responsive to their needs. For instance, one relative told us how the service arranged for an optician to visit one person who was not able to use their glasses. Another person said they were in the process of being moved into a larger room, as they would enable them to move some of their own furniture into their room.

People and their relatives said they knew how to make a complaint. One person said they knew how to raise a complaint and thought staff listened to them. The person said, "Whether or not they did anything about it, I don't know." A relative told us they had not seen the complaints policy but felt confident to address any concerns with the manager. Staff knew how to handle complaints. One staff member commented, "Family members can come to us or they can email the registered manager."

The complaints policy was displayed on the 'Residents and family' noticeboard however, this was not always kept visible. We noted the policy did not list the Local Government Ombudsman's contact details amongst external agencies people could contact if they felt their complaint was not satisfactorily resolved by the service.

Requires improvement

Is the service well-led?

Our findings

Quality assurance systems in place were not effective in assessing, monitoring and improving the quality and safety of services provided. This was because systems in place did not evidence when appropriate action was taken when concerns were identified.

Health and safety audits undertaken were not able to identify safety risks for example, fire doors not opening or jammed and the stair gate being left opened by staff. There were no systems in place to mitigate identified risks relating to people's health. For instance, no risk assessments were put in place for people assessed with identifiable risks. Where people sustained unexplainable injuries, no action was taken by the service to investigate or escalate them to the appropriate agencies. This placed people at risk of unsafe care and inappropriate care.

There was no evidence of what action was taken when tasks were partially completed. For example the catering audit dated 26.10.15 recorded whether all points raised from the previous audit had been addressed. We noted there was some areas that had been partially completed but there was no record to show what those areas were or what action was taken to complete them.

There were no audits of care plans undertaken. This would have picked up on care records not being regularly updated and annual care reviews that were due.

The medicines audit dated 30.10.15 stated five people's medicines had been reviewed over a four week period to ensure medicines prescribed, quantities reconciled and MARS were correct. There was no record of who the five people were and whether there were any identified concerns.

The 'skill soft' staff training matrix for 2015 showed what training staff had undertaken but there was no evidence of action taken to ensure all staff was up to date with relevant training. The manager's monthly report dated October 2015 stated 100% of staff had completed manual handling; 80% health and safety; 90% infection control; 80% for safeguarding vulnerable adults; 80% DoLS; 70% customer care; 90% medication; 90% dementia and 80% food hygiene. We found this to be inaccurate and not in line with training staff had actually completed.

The report listed training staff had completed during the month of October, we noted the training recorded related to training in August 2015. We saw the training matrix had not captured the names of all staff who were employed by the service. For instance, 11 staff members were not listed on the training matrix. Therefore information which related to staff training was not accurate or fit for purpose and meant people were at risk of unsafe care as there was a possibility not all staff had received appropriate training.

Individual emergency evacuation plans were not always reviewed and kept up to date. We noted a person who had recently moved into the service did not have one in place. This meant systems in place were not able to identify where quality was being compromised.

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

Agency staff personal records were not maintained securely. We observed agency staff personal details were kept in the staff handover book. This book was easily accessible to all staff and anyone who wanted to look in it, throughout the working day.

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

Supervision records did not adequately record discussions held with staff. For example, there were no clear records that outlined set deadlines for training to be completed in some of the records reviewed.

People and their relatives thought the home was well managed. We heard comments such as, "I think its well run, I like the people in it and they are friendly to you all the time", "Well they do their best" and "We like it, it's like a little community." One person said they didn't know if the home was well managed or not but knew who the manager was as they would come and speak to them.

Staff spoke positively about the support they received from management. One staff member commented, "Management are supportive and try to understand and listen to you." Another staff felt the home was well led and found the registered manager to be supportive. Staff described the culture of the home as friendly and felt the team work amongst them was good.

Requires improvement

Is the service well-led?

Staff said they were kept up to date with changes within the service and referred to team meetings and handover meetings. This was supported by team meetings notes dated 20 May 2015, 26 August 2015 and 19 October 2015. One staff member said they found the staff meetings beneficial and talked about changes made in response to concerns raised. They commented, “We’re now seeing changes. It’s not 100% but it’s much better than before.”

Relatives’ meetings evidenced people were kept up to date with changes within the service. For example, the relatives’ meeting dated 29 October 2015 showed relatives were being kept informed on the refurbishments being carried out in the home. People and they relatives were able to provide feedback during this meeting.

The service had systems in place to capture complaints received however; it was not clearly recorded if the actions taken was to the complainant’s satisfaction.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not enough staff to meet people's needs. This was because the dependency tool used to determine how many staff should be allocated to meet people's needs was inaccurate. Regulation (18) (1). Staff did not received appropriate induction, training and supervision. Regulation (18) (2) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Quality assurance systems in place was not effective in assessing, monitoring and improving the quality and safety of services provided. Reg (17) (1) Agency staff personal records were not kept securely. Reg. (17) (2) (d).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People did not receive appropriate support at meal times when they needed it. Regulation (14) (4) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment There was no evidence of investigations undertaken when unexplained bruises were found on people's bodies. Regulation (13) (3).

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People's social needs were not being met. Regulation (9)(1) (c) Care plans reviewed did not capture people's choices and preference in regards to end of life care. Regulation (9) (3) (b)

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment No risk management plans were in place where people had been assessed with identifiable risks. Reg (12) (2) (a). Sliding gate situated on main stair was constantly left ajar by staff. Fire doors situated on the first floor were jammed and difficult to open. Reg (12) (2) (d).

The enforcement action we took:
A warning notice was issued to the provider.