Anchor Carehomes Limited

Harden Hall

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 1 and 2 March 2017 and was unannounced. At the last inspection that took place on 11 July 2016 we rated the service as being 'good' however we found improvements were needed in the management of medicines. At this inspection we found these issues had been addressed and the required improvements made. However, we identified concerns with how risks were managed, the number of staff available, how people's dignity was maintained and the leadership of the service and the provider was not meeting all of the requirements of the law. Harden Hall is registered to provide accommodation for up to 54 people who require nursing or personal care. At the time of our inspection there were 49 people living at the service. Most people were living with dementia.

There was a registered manager in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission (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.

People were not supported by sufficient numbers of staff. People had to wait for care and support and they were at risk of harm due to the lack of staff. People were sometimes exposed to harm such as injury due to the ineffective management of risks. People told us they were supported to take their prescribed medicines safely and as prescribed. People felt safe and we could see there was a system in place to take action to investigate where signs of abuse were identified.

People were not always supported by staff that had knowledge and skills to provide effective care. Staff were not aware of how to manage behaviours that challenged and did not follow the training received for reporting safeguarding incidents. People's capacity was assessed where people lacked capacity staff were making decisions on their behalf in their best interests in line with the principles of the mental capacity act. People had a choice of meals and received sufficient food and fluids to meet their needs. People were supported to maintain their health and could access support from professionals when required.

People were not always supported in a way that promoted their dignity and privacy. Dignity was not always promoted due to the insufficient numbers of staff available. People were not always supported with the right equipment to maintain their independence. Some people needed access to equipment to help them eat their meals. People received support from staff that were caring. Staff spent time getting to know people and people told us they had good relationships with staff. People were supported to make choices about their care and support.

People were involved in their care and support. People were able to identify their preferences and these were understood by staff. Staff could tell us about peoples preferences and this was reflected in peoples care plans. People had access to a range of activities and chose how to spend their time. People could make a complaint and complaints were responded to in line with the policy.

The service was not always well led. Some staff felt unable to approach the registered manager and felt action was not always taken to address areas of concern. The registered manager had systems in place to check on the quality of the care people received but they were not always effective.

During this inspection we found the provider was not meeting the requirements of the law regarding safe care and treatment, sufficient numbers of care staff and the effective management of the service. You can see what action we told the provider to take at the back of the full version of the 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 always safe.

People were not always supported by sufficient staff to meet their needs safely.

People were not always supported by staff that understood how to manage risks to their safety.

People were supported to receive their prescribed medicines safely.

People were safeguarded from harm and abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported by staff with the required skills.

People's rights were protected by staff that understood the principles of the Mental Capacity Act.

People were supported to have a choice of food and drink and their nutritional needs were met.

People were supported to maintain their health and wellbeing and access health professionals for support.

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy and dignity was compromised due to ineffective communication and insufficient staffing.

People were not always supported to maintain their independence. People were supported to make choices about their care.

People had good relationships with staff and staff were caring in

their approach.

Is the service responsive?

Good

The service was responsive.

People were involved in planning their care and support and staff understood people's preferences.

People were engaged in meaningful activity and were supported to follow their interests.

People understood how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered manager was not seen as approachable by some relatives and staff.

The registered manager did not always have effective management systems in place.

The registered manager had arrangements to seek people's feedback on the service they received.

Harden Hall

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 1 and 2 March 2017 and was unannounced. Day one of the inspection took place during the night. This was because we had some anonymous concerns about staffing levels and wanted to check the support people received during the night. The inspection team consisted of two inspectors.

We reviewed the information we held about the service. This included statutory notifications we had received, which are notifications the provider must send us to inform us of certain events, such as serious injuries. We also contacted the local authority and commissioners for information they held about the service. We used this information to help us plan our inspection.

During the inspection visit, we spoke with ten people who used the service and seven relatives. We spoke with the registered manager, the district manager, 15 care staff, including five night care staff and two visiting health professionals.

We observed the delivery of care and support provided to people living at the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records about how people received their care and how the service was managed. These included 11 care records of people who used the service, 11 medicine administration charts, five staff records and records relating to the management of the service such as staff rotas, complaints and accident records.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we asked the provider to make improvements to how medicines were administered. At this inspection we found the provider had made the required improvements. However, we found improvements were now required in how people were protected from the risk of harm and the number of staff available to meet needs safely staff. The provider was not meeting the regulations around safe care and support and staffing.

The registered manager had not ensured people were protected from the risk of harm or injury or that staff fully understood how to protect people from the risk of harm. On the first day of the inspection, we found one person had become trapped in their bed rails; care staff told us the bed was new and safety bumpers had not been made available for them to use. This had resulted in bruising to the person. The deputy manager confirmed the bumpers had been ordered and told us staff should be using a duvet to cover the bed rails in the meantime. Staff we spoke with were not aware of this instruction and a risk assessment was not available to provide guidance to staff. Staff had taken steps to move the person to a chair in the lounge overnight to protect them from further injury. However, this meant the person did not get any sleep and was tired during the morning. We observed them falling asleep at the breakfast table and telling staff they were very tired due to them not having slept in their bed the night before. We spoke to the district manager about this incident who advised immediate steps would be taken to protect the person from the risk of further harm.

People who displayed behaviour that challenged were not always supported safely. For example, whilst staff were trying to assist one person to stand up, they were upset and shouting out. The staff were doing their best to calm this person down and explain what they were doing, but the person remained upset and the strategies used by staff were not effective in calming this person down. We spoke with staff and they said this was usual for this person to behave in this way every day and they could only try and offer reassurance. We looked at the care records for this person and found they failed to give guidance to staff on identifying triggers or what action to take to calm the person down and keep them safe. We also found the incident we saw had not been recorded in the person care records, and there was no record of previous incidents, despite staff telling us the person often displayed behaviours which challenged. We spoke to the registered manager about this and they had not been informed about the incident.

One person displayed behaviour which placed other people at risk; the persons care plan did not include what may trigger this behaviour or how staff could prevent their behaviour from escalating. In another example we found there was a sensor in place to alert staff when one person moved from their room. This was because the person displayed behaviours that challenged. However there was no guidance for staff on how to manage the behaviour when it was displayed to manage and reduce the associated risks. We spoke to the divisional manager about this and they said they would review all care plans with a specialist dementia advisor immediately. This showed the registered manager had failed to ensure effective plans were in place to guide staff and help reduce the risk for people with behaviour's that challenged.

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

2014 Safe care and treatment.

There were not always enough staff to meet people's needs safely. People and their relatives told us they thought staff were very busy and there were insufficient numbers of staff available to people. One person said, "I sometimes have to wait for things, you have to be patient". A relative told us, "The staff never have time to talk to people, they need more staff". Another relative commented that staff seemed to spend a lot of time writing records, which meant they could not spend time with people. Staff told us they did not feel there were enough staff available to meet people's needs safely. One staff member commented, "There are people here with challenging behaviour, we need more staff". Another staff member said, "I have gone home upset a few times, it's not fair on the people here". Whilst one staff member told us about a person that had climbed on a chair in the lounge as there were no staff present and was at risk of falling.

Our inspection was conducted partly at night, this was because we had received concerns people were not supported by sufficient staff at night. We found there were not sufficient staff to support people safely during the night. For example, we saw people were left without staff presence in lounge areas, which meant people that were at risk of falls and required supervision were left alone. We saw staff have to leave one floor to offer support to staff on another floor.This meant there were insufficient staff available to monitor people that may be at risk if they got up out of bed. We spoke to the registered manager and the district manager about this and they told us they would urgently review dependency levels and staffing numbers. They confirmed after day one of the inspection they had increased night staff levels with immediate effect. During the day we also found examples of insufficient staffing levels. On one occasion a disagreement began between two people which could have escalated and there was no staff present to manage the situation. We spoke with staff about this and they said the people were known to disagree sometimes and had to be monitored, however due to staffing levels they both had to leave the area so this was not possible. In another example we saw one person asking a member of staff to help them up from the chair, as the member of staff was serving food they had to ask the person to wait. The person waited for 20 minutes before another staff member was free to assist. On the last day of the inspection two members of staff were trying to support four people who were attempting to mobilise independently. One person was trying to get to the toilet and was removing their clothing whilst walking in the corridor. Staff tried to offer support to everyone, however as people were mobilising in different areas an inspector had to intervene and provide support as there were insufficient staff available to keep people safe. We saw the care plans for these people outlined they required supervision when mobilising either due to posing a risk to others or being at risk of falling.

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

People received support when they had an accident and action was taken to prevent reoccurrence. We saw accident reports were completed and the registered manager took action to prevent any further accidents. For example, mobility assessments were reviewed, falls prevention services were used and care plans were updated. The registered manager told us they reviewed all accidents to look for patterns and to identify what action was required to mitigate the risk of reoccurrence.

People were supported by staff that had been recruited safely. We looked at staff files and found checks were carried out before staff started their employment including references and work history. We saw staff had a satisfactory Disclosure and Barring Service (DBS) check in place. The DBS checks help employers make safer recruitment decisions in preventing unsuitable people from working with vulnerable people.

People received their medicines as prescribed. People told us they were happy with the support they

received with their medicines. Staff told us they had protected time for medicine rounds to be undertaken; we confirmed this through our observations. Staff told us they received medicines training and their competency was checked by the registered manager, the records we saw confirmed this. We saw staff administer people's medicines safely. For example, staff checked medicine administration records (MAR) before administering any medicine and signed the record after administration. We saw people were prescribed medicine on an 'as required' basis and we saw that guidance was in place for staff about when this medication was needed. Where people required medicines to be administered covertly there were clear instructions for staff about how to do this safely with advice from the pharmacist available. There were suitable facilities for storing medicines and they were stored safely and there were daily audits of medicine stock completed. This showed people were supported to receive their prescribed medicine safely.

People and their relatives told us they felt safe using the service. One person said, "I feel safe, it's the friendships you have and the help you get that makes you feel safe". A relative said, "[My relative] is looked after really well, I know they are safe". A visiting health professional said, "I think people are safe here, it's the sort of place I would want my parents to be". Staff could describe for us how they would identify potential signs of abuse and what action they would take to report this. One staff member said, "I know that if the manager does nothing to deal with things, I can whistle-blow". Staff could give examples of situations where they had reported incidents which had been investigated as a safeguarding concern. We saw that the registered manager had made sure there were guidelines for staff to follow about reporting abuse and staff had received training. However we could not be assured staff were recording and reporting all potential abuse to the registered manager. For example, staff told us about a person that was aggressive towards staff and another person on two occasions; we could not find reference to these in the incident logs or care records, we asked the registered manager to investigate these historic incidents. We could see where the registered manager had been informed of incidents they had followed the safeguarding procedures in the home and allegations or suspicions of abuse were investigated and reported to the appropriate body. This showed people were not always supported by a staff team that understood how to protect them from harm.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us they felt staff were well trained and had the skills to meet people's needs. Staff told us they had training in key aspects of their role for example, manual handling, food hygiene, and safeguarding. One staff member said, "The training is good, you can log on at home and work through the training, there is a test at the end to make sure you have understood". The registered manager told us some training was delivered by the management team, for example manual handling. We saw manual handling training was taking place during the inspection. Staff used appropriate methods to support people with their mobility and transfers. We saw staff used their knowledge of people's health conditions to monitor their health and escalate if there were any concerns. We saw staff used their skills to provide safe medicine administration.

However we saw staff did not have the skills to support people that displayed challenging behaviour. We spoke with staff about this and they told us they felt as though they needed more training in this area. One staff member said, "We need managing behaviour's training more often, there are a lot of people here that display behaviour's which challenge". We saw staff sometimes were unable to identify triggers where people displayed challenging behaviour and did not always know how to support people and calm them down. This meant staff were unable to provide effective support where people displayed challenging behaviour. We spoke to the district manager about this and they told us they would arrange for additional training for staff on managing behaviour's that challenged.

Staff had refresher training in key aspects of their role for example, safeguarding medicines administration and manual handling and had individual opportunities to discuss their role with the registered manager and team meetings were held. However we found staff were not always following the procedures they had been shown with regards to safeguarding. Staff told us they received an induction which included five days training and shadowing shifts. One staff member said, "The induction lasts between one and two weeks depending on experience". We saw records of inductions carried out with staff which confirmed what we were told.

Staff told us they always sought consent from people before offering care and support. One staff member said, "You have to approach people and ask for consent". Another staff member said, "If people do not give their consent, I walk away and try again later". Throughout the inspection we saw staff cared for people in a way that involved them making choices and decisions about their care. We saw staff checking with people that they consented or were happy for staff to assist them with everyday tasks. For example, when offering people their medicines.

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's rights were protected. Where staff were required to make decisions on behalf of people who lacked capacity we saw these decisions were made in people's best interests in line with the

requirements of the MCA. For example, staff were making decisions about some people's medicines and equipment they required to keep them safe. They had appropriately considered these people's capacity and had consulted with family members and healthcare professionals where appropriate This showed the registered manager had systems in place to protect people's rights.

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 are called the Deprivation of Liberty Safeguards (DoLS). We saw the registered manager had identified people that may be having their liberty restricted to ensure their safety. They had made the appropriate applications to the local authority for a DoLS authorisation. People's rights were being protected appropriately by staff. This showed the registered manager had systems in place to make applications for DoLS and monitor their application.

People were supported to have a choice of food and drinks. People and their relatives told us the food was good quality and they could choose what they wanted to eat. One person said, "The food is good, breakfast was really lovely". A relative said, "There is a good choice of food and drinks here". Staff told us people could choose what to eat and drink and they were supported to make decisions. We could see there was a choice of food and drinks offered to people throughout the inspection. People were supported to meet their nutritional needs and preferences. Staff could describe people's nutritional and hydration needs and could tell us how they supported people. For example, they could describe where people were at risk of malnutrition and what actions were in place to mitigate the risk. Staff could describe how they supported people who were at risk of choking. One staff member said, "We have to use a thickener for [a person's name] to make sure they have their fluids safely". We saw risk assessments and plans for mitigating the risks were available in people's care plans, we observed staff following these instructions. Where people needed support to eat and drink, this was given by staff at a pace which suited the person and with patience.

People were supported to maintain their health and wellbeing. One relative said, "The staff act quickly if there are any health concerns". Another relative said, "There has never been any problem with getting a visit from a doctor". A visiting health professional told us, "The staff here are very good, this slightest thing and they seek support". They added, "Staff always follow through with any instructions given". Staff told us how people with specific health conditions were monitored; they could describe how they supported people to maintain their health. For example, they could describe how they supported people to prevent pressure sores. We saw staff were proactive in reporting any health concerns. Records demonstrated where staff had sought advice from doctors, nurses, dieticians, and falls prevention specialists. We could see records of visits being requested promptly and instructions from the visit recorded. We could see where advice was given about people's health this was followed. For example, one person had been identified as not eating and drinking well. They had been referred to the doctor and the dietician and a care plan had been put in place with monitoring of weight and intake. Staff could describe this person's care plan in detail and tell us how they monitored intake and their weight. This showed people were supported to maintain their health and wellbeing.

Requires Improvement

Is the service caring?

Our findings

People's privacy and dignity was sometimes compromised due to the availability of staff and equipment.

Whilst people and their relatives told us staff observed people's privacy and they treated people with dignity we saw some examples where this was compromised through the availability of staff. For example, one person was walking in the corridor attempting to take their clothing down as they needed the toilet; there were no staff to support this person. Staff communication systems were not effective, this meant staff were unaware of issues which had an impact on peoples mood and care and support needs. For example, staff continually tried to rouse one person to eat their breakfast, they were not aware of the poor nights sleep this person had. Inspectors had to intervene and explain this person was possibly tired. We also saw there was limited access to equipment to promote independence, which had an impact on peoples dignity. For example, the lack of cutlery and cups meant people were using their fingers to eat their meals. However we did see staff spoke to people respectfully, addressed people by their preferred name and approached people discreetly when they were offering them care and support. We received some positive comments from people, relatives and staff. One person said, "Staff are always very respectful". Another person said, "Staff always knock the door". A relative told us, "I do think the staff look after people's privacy quite well". Staff told us they understood how to maintain people's privacy and dignity. They told us they always made sure they knocked doors, closed curtains and covered people whilst supporting them with personal care.

We saw staff encouraging people to support themselves, such as walking independently. People also told us they were able to do some things for themselves without help from staff. For example one person told us they were able to manage their own personal care. Staff confirmed this was the case and the records we saw supported this. We saw people were encouraged to walk when they were able, with staff support to ensure their safety. This showed staff encouraged people to maintain their independence. However, we saw people were not always given appropriate equipment to enable them to eat their meals independently, for example plate guards and adapted cutlery. This meant some people were trying to eat their food with their hands. We spoke to the registered manager about this and they said they would review the equipment available and consider peoples individual needs.

People had good relationships with staff that were kind and caring in their approach. People and their relatives told us staff were kind and caring and they had good relationships with people. One person told us, "The staff here are very good". Another person said, "The staff treat us how they would want their mother or father treated". A relative said, "The staff are very caring, they do what they are supposed to do and more". Staff told us they spent time getting to know people; they said it was important to develop a relationship with people and their relatives. We observed how staff interacted with people. People smiled warmly and responded to staff when they spoke to them. We saw one staff member walking around the corridor holding hands with a person.

Staff supported people to maintain relationships. For example, one person was enabled to move to sit next to someone who they liked to spend time with. Visitors were able to come at any point throughout the day, we saw they were welcomed by staff and given the opportunity to visit in private. This showed people had

positive relationships with staff and that staff provided care and support in a caring and respectful way.

People were able to make choices and preferences about their care and support. One person said, "I can choose everything for myself, such as when to get up, what to eat and when to spend time in my room". A relative said, "There is not a problem, [a person's name] can choose for themselves in everything they do". Staff supported people to choose things for themselves. They told us people chose when to get up, where to go, what to eat and drink, what to wear and how to spend their day. We saw staff ensured people could choose for themselves. For example on person chose where to sit, another person chose to take part in an activity. We could see records showed staff information about peoples preferences, in particular where they may need support to make decisions.

Good

Is the service responsive?

Our findings

People told us they were involved in all aspects of planning their care and support. They told us they were involved in the assessment of their needs and in all decisions about how their care and support would be delivered. Relatives also told us they had been involved in discussions about people's needs. One person told us, "The staff go out of their way to try and find out what you like and don't like, they really get to know you". A relative told us, "They are really good at keeping us informed about [a person]". Staff could describe people's needs and preferences. One staff member was able to describe how one person loved to sit and do some colouring. Another staff member told us about a person who liked to have specific personal items in the basket on their walking aid. Records showed details of people's preferences and we saw that staff followed these as they were outlined in their care plan. . For example, one record showed one person preferred not to eat their meal at the table. In another example, the care plan stated one person preferred to use the toilet in their own bathroom.

People and their relatives told us there were things for people to do and the entertainment was good. One person said, "They have quizzes here and I have my daily paper to read". A relative told us, "its good entertainment, they have singers coming in to sing the old songs with people". However, one relative told us they did not feel staff had enough time to spend talking to people. A visiting health professional said, "I come here every day and there is always something going on for people, especially in the afternoons". Staff told us people were engaged in different activities and there were planned activities during the day. However staff said the staffing levels did impact on how often people could go out and they would like the opportunity to be able to take people out. We saw activities taking place during the inspection and we saw staff offering people choices about what they wanted to do. For example, we saw one person being supported to join in a group activity. We saw another person being supported to spend time colouring whilst someone else was supported to speak with their relatives in a quiet area. We looked at people's care records and found they included details about how people liked to spend their time, and this was reflected in what we saw people doing throughout the inspection. We spoke to the district manager about activities and they told us this was an area that was due to be reviewed to consider what people would like to do. . This showed staff supported people to engage in activities of their choice.

People were able to make complaints. People and their relatives told us they understood how to make a complaint and felt this would be addressed. One person said, "I have no complaints about anything, I would speak to staff if I did". A relative told us, "If I had any complaints I could speak with the registered manager about them". Staff understood how to deal with complaints. One staff member told us, "You have to take a note of the details, listen to what people are saying and then refer it to the manager". Another staff member said, "All complaints are recorded in the office". We saw records of complaints which had been made by people and relatives. However we did receive some feedback from relatives which suggested they found it difficult to approach the registered manager. We saw these had been acknowledged and investigated. The outcome of the investigation was shared with the complainant. For example, one complaint about a lack of information, the investigation found the person had not been adequately informed, this was shared with the complainant along with an apology. The registered manager told us all complaints were logged and reviewed and the information was used to make improvements to the quality of the service. This showed the

registered manager had a system in place to investigate complaints and people were aware of how to access this.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had some effective systems in place to check the quality of the serivce. For example medicines administration, issues were identified through the monthly audit and these had been acted on. We saw there were infection control audits in place which enabled the registered manager to check the standards of cleanliness and control the risk of infection. However despite some governance systems being effective this was not consistent across all areas of the service.

Staff expressed they did not always feel the registered manager took notice when they raised concerns. They told us they had raised issues about the staffing in team meetings but nothing had been done. One staff member said, "I have been here for two years, and at every meeting we have asked for more staff and nothing has changed". Another staff member said, we have raised the issues with the registered manager about staffing many times, I think they have raised them with the provider, but nothing changes". We found staff had raised their concerns about insufficient staff being available with the registered manager in a staff meeting, and despite assurances that action would be taken, staffing was still insufficient at the time of the inspection. The district manager told us they would meet with staff and discuss their concerns about issues raised not being addressed. This meant the systems in place to enable staff to raise concerns about the quality of the service had not been effective in making improvements.

The registered manager had a system in place to assess the dependency levels of people that used the service and identify how many staff were needed. However, they told us the system relied upon their observations and the daily records completed by staff. We found daily records were not always reflective of the level of need people presented with, as staff did not always accurately record the level of input they had to give to people, in particular around people with behaviour's that challenged. This meant the system in place was not effective in identifying dependency levels of people which had led to insufficient staff being available.

Communication systems were not always effective. The registered manager did not ensure effective systems of communication were in place to tell staff about changes to people's health and wellbeing. For example, during the inspection one person had an accident; this was not reported to staff during the handover we observed. Staff told us they were not always communicated with when things changed for people, for example where people needed to be monitored due to their health. This meant effective monitoring was not carried out for this person.

The registered manager did not always have systems in place to ensure people received the care they required. For example there were ineffective systems to ensure risks to people's safety were appropriately managed. We also found there were unrealistic expectations placed on staff to monitor people continually, without sufficient resources to do this effectively. For example, there were not enough staff to monitor people safely through the night. Staff were not given effective guidance on how to support people with behaviour's that challenged. For example, staff did not know what to do when one person was moving around the building, they had an alarm raised to alert them as the person posed a risk to others, however there was no detailed guidance on how to keep people safe. This meant the registered manager could not

be assured people were having their needs met safely by staff.

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

We looked at the statutory notifications which we had received. We saw that we were notified of events and incidents in a timely manner.

Most people and their relatives were complimentary about the atmosphere in the home and the relationships with the registered manager and staff. One person said, "Everyone here is very pleasant and helpful". A relative said, "The registered manager is very busy, but they are always approachable". However one relative said they had experienced poor communication with staff not remembering appointments and they had not always found the registered manager to be approachable. People who made formal complaints received a response and this was used as a learning tool for managers and staff to drive improvements. However some relatives told us they did not feel able to approach the registered manager with their views about the service. They shared examples of where they had not received an effective response.

Staff had mixed views about the atmosphere in the home. Some staff felt the teams worked well together and they could always approach the registered manager about things. Whilst others felt the registered manager was not always easy to talk with and there were issues between different staff. One staff member said, "I feel I have enough support from the registered manager, but I don't feel they are supported by the provider". Another staff member said, "There is a good sense of teamwork here". Some staff however told us they had concerns about approaching the registered manager and did not always find this easy. This meant staff could not always approach the registered manager with their concerns. We spoke to the district manager about this and they told us they would speak with staff and consider this issue. During the inspection we saw staff were participating in a survey about the quality of their service the district manager told us this would be used to understand staff concerns and consider improvements.

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 12 HSCA RA Regulations 2014 Safe care and treatment People who use services were not supported to manage risks to their safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager did not have effective systems in place to check the quality of the care people received.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were not supported by sufficient staff to meet their needs.