

Mr and Mrs N Squirrell

Glebe House Retirement Home

Inspection report

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Date of inspection visit:

29 September 2016

04 October 2016

Date of publication:

09 January 2017

Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

Glebe House Retirement Home is owned by Mr and Mrs N Squirrel. It provides accommodation and personal care and support for up to 19 older people. The adapted building offered accommodation over three floors. The service is supporting a range of people's needs, including people living with dementia. Nursing care is not provided at Glebe House Retirement Home.

This unannounced inspection took place over two days, 29 September and 4 October 2016. At the time of the inspection there were 16 people living in the service.

There was a registered manager in post who also co-owns the service. 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.

Improvements were needed in fire safety and the storage of hazardous fluids. The service needs to ensure that the checks in place to monitor the safety of the environment are effective enough and meets current guidelines and that staff are competent in the use of fire extinguishers and evacuation equipment. Further work is needed to ensure identifying and acting on any potential risk is embedded in staff practice.

People told us they felt safe. Staff understood their responsibilities to ensure people were kept safe from abuse and knew who to report their concerns to within the service. However, if the need occurred, not all were aware of the external safeguarding agencies to contact.

People and their visitors spoke about the caring staff and friendly atmosphere of the service. Staff had good relationships with people who used the service and spoke about them in a caring and compassionate manner. However, improvements were needed in the staffing levels and knowledge in supporting people with dementia, to ensure all interactions with people are meaningful and caring. Also in the range of activities offered to prevent the risk of social isolation. We have made recommendations to support the service in identifying how many staff they need and in improving staff's knowledge of dementia care, and arranging stimulating activities.

People were supported by staff to take their medicines as prescribed. Health care needs were met through developing good working relationships with external health care professionals.

The service was in the process of implementing new care plans. Improvements were needed in how people's ability to make decisions were assessed and recorded. We have made a recommendation to support the service in ensuring any restrictive practices are lawful.

People told us that the 'home cooked' food was good, and that they were supported to have enough to eat and drink. Dietary needs and nutrition were being monitored and advice sought from appropriate health

professionals as needed. However, improvements were needed in people's dining experience.

A complaints procedure was in place to ensure people's comments, concerns and complaints were listened to and addressed in a timely manner. There were systems in place to seek the views of people using and working for the service. However we have made a recommendation to further build on the work being undertaken. This is so people and staff can be more influential in driving improvements.

The service had checks in place to monitor the running of the service. But improvements were needed to ensure they were able to independently identify any shortfalls in the quality of service being provided as part of driving continuous improvements.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not consistently safe.

People were not provided with a safe environment. Improvements were needed to ensure any risks to people safety and welfare were identified and acted on.

Risks to people's welfare were assessed. Staff knew how to keep people safe from abuse. However, not all staff were aware of the role of external safeguarding agencies and how to contact them.

There were not sufficient numbers of staff to consistently meet people's needs safely.

Is the service effective?

Requires Improvement ●

The service was not consistently effective

Improvements were needed in how the service ensured people's legal rights were protected.

Staff received training but not always put into practice. We found shortfalls in staff's knowledge of supporting people living with dementia.

People had access to a choice of home cooked food and snacks which met their dietary needs and preferences. Improvements were needed in the dining experience of people.

People were supported to maintain good health and had access to appropriate services which ensured they received ongoing healthcare support.

Is the service caring?

Requires Improvement ●

The service was not consistently caring.

Staff were kind and compassionate, however improvements were needed to ensure all interactions were respectful and supported people's independence and choice.

Is the service responsive?

The service was not consistently responsive.

Improvements were required to ensure all people had access to mental stimulation through meaningful activities.

Improvements were needed in how people's care was planned and provided.

People's concerns and complaints were investigated, responded to and used to improve the quality of the service.

Requires Improvement 

Is the service well-led?

The service was not consistently well-led.

The quality of the internal assurance systems in place were not robust enough to drive improvement.

Feedback from people and relatives were complimentary about the welcoming and friendly culture of the service.

Requires Improvement 

Glebe House Retirement Home

Detailed findings

Background to this inspection

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

This inspection took place on 29 September and 4 October 2016 and was unannounced. The inspection team consisted of one inspector on the first day, and two on the second day.

We looked at information we held about the service including notifications they had made to us about important events. We also reviewed all other information sent to us from other stakeholders for example the local authority and fire safety officer.

We observed the care and support provided to people and the interaction between staff and people throughout our inspection. 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.

As part of this inspection we met nine people using the service. We spoke with two people's relatives, three health care professionals and two fire safety officers. We spent time with the registered manager responsible for running the service, and seven members of staff, which included assistant manager, senior care, care, catering and domestic staff.

We saw records relating to five people's care, three staff files and records relating to the management of the service, recruitment, training and systems for monitoring the quality of the service.

Is the service safe?

Our findings

Improvements were required in risk management to ensure the safety of those living, visiting or working in the service.

The fire risk assessment, fire alarm detection system, staff training in the use of fire extinguishers and evacuation equipment in the event of a fire, were not effective enough. On the 29 September 2016, there was one member of staff on night duty. If a fire occurred, they were responsible for telephoning the providers who lived next door to the service, as the fire alert system was not linked between premises. They would also need to check where the fire was, and take any immediate action to ensure people's safety, such as evacuation if needed and meeting with the emergency fire service to advise of important information they may need. All of these tasks would be too much for one member of staff to do efficiently and safely. This showed that appropriate assessments were not in place to reduce the risks to people in the event of a fire.

Staff were not always identifying, and taking action to address potential risks. For example we saw three bedroom doors had been wedged open and another two which had automatic closures fitted had items blocking them. Therefore these doors would not provide an effective barrier if a fire occurred. We contacted the fire safety officer, who carried out a fire safety audit on the 30 September 2016. This resulted in the service being required to address the fire deficiencies, and a further visit in 2017 to check that the required work has been addressed. This included having a more robust evacuation plan in place.

Improvements were also needed to ensure all chemicals which were hazardous to health were secured correctly. The laundry which had restricted access, cleaning fluids were being stored along with information sheets on using them safely. However, we also found unsecured cleaning agents, on the floor near a person's bedroom who could be confused and there was a risk that this person or others could access them. This could include drinking the items or spilling them onto their skin. There were also cleaning agents in an unlocked cupboard, which had hot water pipes and a hot water tank. No checks were in place to ensure that the cupboard was not too hot for the safe storage of these items. Some cleaning fluids had been decanted into clear containers. Where a marker pen had been used to write the name of the product some had partially worn away; making it difficult to read, in addition the labels advising, for example if the items were corrosive were not in place. Therefore staff could not be assured what the contents were. This is important because if a person did access these items and ingested them, in staff acting the relevant safety data sheet, and what actions they should take to ensure the person's health and well-being.

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

The provider took action during the inspection, by removing the door wedges, and clearing stairwell and stairs. They also arranged for a member of staff to sleep in that night on call, whilst more permanent arrangements were put in place to increase the waking night staff to two. They also removed the cleaning fluids stored in the hot cupboard.

People's care records showed action taken to reduce individual risks. Where a person identified as being at

high risk of falls, control measures had been put in place to prevent / reduce the risk of injuries through falls. This included sensor mat to alert staff if the person had got up so they could offer safe assistance and support.

People told us they felt that were provided with safe care. One person told us, "I trust," the staff looking after me.

Staff were able to explain what they would do if they had concerns of abuse. This included their duty in reporting any concerns which could impact on a person's safety and human rights to senior staff. The assistant manager knew how to access the local safeguarding web page and make a safeguarding referral direct, also the contact number to telephone if they needed to seek advice. However, not all staff were aware of the external agency responsible for safeguarding, or how to contact them.

Training records showed all but one of the care staff listed had received training in SOVA during the last two years. Out of the six ancillary staff who had regular contact with people (cooks, domestics and maintenance person), records showed one had received SOVA training. Improvements were required to ensure that all staff had a good working knowledge in recognising signs of potential abuse, and who to report concerns to externally as well as internally.

There was no effective system in place to demonstrate how the leadership calculated the staffing levels, deployed across the service. This is to ensure it was safe and met people's changing needs. Feedback we received from people living in the service, health professionals and staff, identified that people living in the service were becoming more mentally and physically frail. However staffing levels were not being adjusted to reflect this.

A visitor remarked that, "There are always staff around, it's all very nice." One person commented, "It's a bit spasmodic in the morning." Which was our observation as staff brought people into the dining room for breakfast, then left to get someone else up. One member of staff was responsible for administering medicines, preparing and serving breakfasts. We also saw them answering the telephone and supporting a visiting health professional. Staff told us this was usual practice and it was left to the remaining three care staff to assist people getting up, supporting with personal care and bathing. This included five people who usually required the assistance of two staff.

Health professionals and staff identified that people's physical and health needs were being met. A member of staff remarked, "For what we've got [staffing levels] the care is good. We always work as a team." Call bells were being answered promptly, which ensured people's requests for assistance were responded to. However staff were constantly on the go, working as a team and taking over from each other to complete tasks during busy periods. This can impact of the people's continuity of care. For example, at lunch time, one person was assisted by three different members of staff as they came in and out of the dining room. There was no explanation to the person which did not provide a positive and calm dining experience for them.

We recommend that the service uses a reputable source to assist them in calculating the staffing levels; which takes into account the layout of the service and people's dependency needs.

Records showed that checks were made on new staff before they were allowed to work alone in the service. These checks included if prospective staff members were of good character and suitable to work with the people who used the service.

One person told us they received their medicines as prescribed, "Four times a day." We observed staff safely administering breakfast and lunch time medicines. Staff were checking people's records to confirm that they were administering the right medicine to the right person. When staff entered people's bedrooms they introduced themselves, confirmed what medicines they had brought with them, and offered assistance as required. This included checking to ensure the person had a drink to help them swallow. Then updating the person's medicines records to confirm they had been given.

People's medicines were stored securely, recorded and administered appropriately. Records confirmed that only staff who had been provided with medicines training, and had their competency checked, were allowed to administer medicines. Records showed that the provider took immediate action to address any identified shortfalls through one to one supervision. This reduced the risk of it happening again, supportive of having safe medicines systems in place.

Is the service effective?

Our findings

People told us that staff had the skills to meet their needs. One person described the support they received from staff as, "Excellent, absolutely excellent, not as young as I used to be, need more help now," and felt that the staff had the skills to provide it. One relative told us that staff had the necessary skills, "Very much so," and spoke about how the person had, "Physically improved," since they had moved in. This they accredited to the level of support the person was receiving.

We found some of the interactions with people living with dementia, lacked insight in being able to support people effectively. For example a member of staff asked a person, "Where do you want to go?" they replied, "Home." The member of staff commented, "We all want to go home." This demonstrated a lack of empathy and understanding of how to support the emotional needs of people living with dementia.

Staff told us about the mixture of practical and 'on-line' training which they accessed to enable them to support people effectively. This included dementia awareness training.

We recommend the service explores current guidance from a reputable source about available training and resources, based on best practice, in dementia care.

The provider had systems in place to provide all new staff with an insight into their role and to support them in getting to know the individual routines and preferences of the people they would be supporting. A staff member told us, "I did shadow shifts and would come in to go through policies and care plans." This enabled new staff to put their training into practice, and gain further insight and confidence in their role alongside an experienced member of staff.

There were systems in place to support staff through supervision and appraisal of their work. A staff member spoke about the benefits of gaining feedback on their practice, discussing future training and progression, and how they can be supported to do this, "They've given me opportunities and responsibilities." Records showed where staff had received 'spontaneous' supervision in response to addressing concerns raised. This showed where supervision was being used as a method of improving practice and where applicable, further training needs to drive improvements.

People told us they were given a choice of meals and were supported to ensure that they were given enough to drink. One person commented, "I really enjoy all the meals, the catering here is suburb." Another told us, "Nothing is brought in from outside, everything home cooked." Another person said that they would have liked a different breakfast option, but instead they had chosen the one they felt would be the least work for staff, "I feel bad if they just have to make it for me."

Further work was needed to ensure meal times were a positive experience and supportive of person centred care. The quality of people's dining experience varied. Where we saw good practice, for example a member of care staff explained to a person what was on their plate so that they could understand what they were about eat. In contrast, another person who struggled to eat their meal, none of the staff stayed long enough

in the dining room to provide effective support. As a member of staff took the plate away, so they could serve the desert, the person commented quietly, "I haven't hardly eaten anything." Another person sat at the table for a long time banging their cup on the table. They had sandwiches in front of them but didn't really attempt to eat them. Staff kept walking through the room but not staying for long. They did approach the person but none of them were aware of what support other staff had given. They encouraged the person to drink but little encouragement was given to help them to eat. Their care plan stated, "Needs a soft diet at all times. Will sometimes need assistance with feeding." This showed that the staff were not always supporting people to meet their individual needs.

Care plans showed that people's nutritional needs were being assessed. Where staff had concerns about a person's nutrition their records showed they had involved appropriate health professionals. One of the catering staff told us how they fortified foods to increase the calorific contents of foods, to promote weight gain in people of low weight. Also how they promoted healthy eating by offering, "Three fresh vegetables" choices with the main meal, and making their own nutritious soups. During the night, staff had responded to a person's request for toast and tea. Catering staff confirmed that they always had a, "Well stocked larder," which staff could access to accommodate people's individual requests.

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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found improvements were needed to ensure that the management and staff had a clear understanding of DoLS and MCA within the care home setting. A staff member told us, "I've done mental capacity training but not the other one [DoLS]." Another said, "DoLS I'm not aware of, I've had no training. I've not had mental capacity training." Records showed that all but three of the care staff had received training in these subjects.

One person told us, "I have no authority to say I can go out. They'll say straight away, sorry, we are looking after you. You can't go out on your own. They would not let you out without somebody or two people keeping control, in case you went mad I suppose." Staff identified people who lacked capacity would need an escort to ensure their safety when they left the service. One staff member said, "A lot of the residents would make their own decisions. Some of them would not have capacity." A person's care records showed that the service had carried out capacity assessments in 2014 and 2016. These identified that the person could go out 'Under supervision only.' However, the management confirmed that no DoLS application had been submitted. This showed that the service was not up to date with DoLS and people may be deprived of their liberty and appropriate referrals had not been completed to ensure these restrictions were lawful. We recommend that the service accesses a reputable source to support them in keeping their knowledge of MCA and DoLS updated, to ensure any restrictive practices are lawful.

People were supported to maintain good health and have access to health care support. Visiting healthcare professionals told us that staff were observant and did not hesitate to call them out if they had concerns about a person's health. They felt Glebe House had a good reputation and said staff always implemented

the advice and instructions given by the healthcare professionals. We saw this reflected in people's care records. People's day to day health needs were met effectively.

Is the service caring?

Our findings

Improvements were needed to ensure all interactions ensured that people are treated with respect and dignity at all times. We saw some caring interactions where people felt valued, looked relaxed and smiled as staff involved them in making decisions. They showed compassion and empathy and acted on what the person had asked them. However others were not as caring and did not demonstrate effective communication. This was because they were task led, and did not focus on the person's wellbeing. For example, a member of staff asked, "[Person] are you having a coffee?" then walked away. The person called after them, "I'd rather have a coffee," and explained to us, "Its coffee time." Later another person was asked if they'd like a biscuit but was given no choice of what type of biscuit. The person who had asked for the coffee had not been offered one but again called after the member of staff. "I'd like a biscuit."

A staff member approached a person who had fallen asleep at the table. They tried to wake them, informing them it was time to move away from the dining area. The person was quickly moved away in their wheelchair, despite not being given the opportunity to wake fully. This could have been disorientating for the person. Where one person was spoken to appropriately and shown empathy when being supported by staff to mobilise, another person was given instructions to, "Stand up ...sit down," without any compassion or encouragement we had previously seen used.

One person was becoming distressed about the number of cars in the car park outside. A member of staff commented, "Alright, eat your lunch." Then quickly left them without giving any reassurance.

Where a person had requested staff's assistance to lie on their bed, rather than act on their request straight away, we heard the person's request being debated by staff. When we asked why, we were told it could lead to an increase in the person using their call bell. This showed that people's choices were not always acted on. The registered manager said they would look into the incident, confirming that all interactions should be person centred.

All the people we spoke with described the atmosphere within the service as welcoming. One person told us, that they enjoyed staff's company and that they, "Laugh a lot together...I start it off." Another person commented, "I love the staff, get on very well with them," and that they were caring and treated them in a respectful way. A relative said, "I think this is a lovely place, everyone is friendly."

Staff spoke about the positive relationships they had built up with people. One staff member said, "The care we give is good, it's very warm. We have really good relationships with residents and their relatives...the carers here are fantastic and all put the residents first." Another staff member commented, "I feel like everyone [staff] knows the residents, in and out. If they want to say something they will. There are no secrets. Nothing is unsaid. Like if they want to have a bath at a different time then that's ok." This reflected the positive feedback we had from health professionals and compliments the service had received. This included from one relative, "I would like to thank you all for the kindness and care that you have extended to [person] over the years."

People were supported to maintain relationships with friends and relatives who mattered to them. We saw people's relatives and visitors arriving on both days of the inspection. A relative told us they visited whenever they wanted and were always made to feel welcome, "Always get offered tea and biscuits...I wouldn't mind coming here," when the time was right.

The service supports people with early stage dementia, when people are at risk of losing their independence because they can become disorientated. However we found the lack of signage in some areas, for example where there were no toilet or bathroom signs to support people in locating these rooms.

We recommend that the service uses a reputable source and latest guidance to support them in identifying and providing an environment, supportive to people living with dementia.

Is the service responsive?

Our findings

The service was in the process of introducing a new care plan format. The registered manager said they had already received a compliment from a health professional who liked the new way the information was being structured. As the management team had only just started the process of implementing the new care plans. In taking their time and not replacing the person's care plan until the new format had been fully completed would ensure no information is lost, which could impact on people's care, during the changeover.

We looked at both the old and new style care plan formats and found the information written in the new format was written in a more person centred manner. The previous care plans were not person centred and did not detail how people's mental, emotional and social well-being were met. For example, more information was needed on how each person would be supported, taking into account their physical and mental frailty. This was to ensure people had access to activities / interactions which provided mental stimulation to enhance their well-being. Daily activities recorded in people's care records were people spent their day. For example 'lounge,' visit,' 'room,' and 'down for lunch.' These did not reflect the quality of the person's day and their wellbeing.

Improvements were being made in the new style care plans. For example, where 'yes/no' tick boxes had been replaced with information about the person to support personalised information. This included giving the person's preferences about washing and dressing, "I like a bar of soap to wash with. I like [type of cream] on my back." There was also information on the person's 'typical day' routines, including what would make 'a bad day to me,' for example, "When it is pouring with rain," Also what would make a good day, "Feeling well and my family visit." The new style care plan we looked at still had sections that needed to be completed this included communication and 'resident's profile.' These improvements were not yet fully implemented to show that people were provided with personalised care which was tailored to their individual needs.

People told us that they could have visitors when they wanted them, which reduced the risks of them becoming isolated or lonely. However records showed that there was limited opportunity for people to participate in activities that interested them. When asked about activities taking place, one person said, "Sometimes...not often, sometimes a [visitor] from the church comes. There's not much going on. Sometimes the days are long. Now and then there is a sing along and a choir, at Christmas mostly." Another person commented, "Not much going on, but that suits me fine," as they enjoyed their daily walks around the large gardens. A visitor told us, "I was here a little while ago on someone's birthday. They had a little sing song."

Care staff said that providing activities was part of their role, but found it difficult to fit in with their other care duties. One staff member said that people, "Have their activities. We try and have an activity before lunch. We take them to the Suffolk Punch for coffee on a Friday if we have enough people here. There is always something going on. A lot of them don't want to participate, they just sleep." With people saying they would like to have more going on in the service, and staff commenting that people were falling asleep, which we observed, rather than joining in, this could indicate that the type of activities provided were not meeting

people's preferences / needs.

We recommend that the service consults with people and uses a reputable source to support them in identifying activities which people are interested / able to participate in.

People knew who to talk to if they had any complaints. One person told us they would speak to the management team, "But I have no complaints." There was a complaints procedure in place which was displayed in the service, and explained how people could raise a concern. We noted there were no timescales given, which would be useful for the complainant in knowing how long it would take for their complaint to be addressed. There were systems in place for recording, investigating and responding to complaints. Records showed where complaints had been raised; they had been investigated and responded to. For example taking immediate action to restore hot water after a complaint had led to identifying the boiler had been turned off. The management team confirmed that they used feedback from concerns and complaints as a learning opportunity, as part of improving people's experiences of the service.

Is the service well-led?

Our findings

The quality assurance systems in place needed to be more robust to support the provider in monitoring the service's routines. This is to ensure that staff's practice was underpinned by the values promoted by the service on their website. This included ensuring people's 'rights are upheld and respected including freedom of choice'. Where staff told us that people had to be in bed by the time the night staff came on duty and they would be told off if this didn't happen, this did not reflect the value that the service was promoting. The registered manager provided reassurances that this was not happening and that people were supported to go to bed when they wanted. The conflicting information we received from management and staff identified that further monitoring of staff's practice, for example using periods of observation, would be supportive of quickly identifying and acting on any routines that had developed, that didn't reflect the service's values.

The management team were responsive in dealing with concerns identified during the inspection, from us and the fire safety officer, which reduced any potential risk and impact on people. This included putting in place a new staff call out system, triggered in the event of a fire to move people to a place of safety. They took action to ensure confidential information about people and staff were moved from the open linen cupboard to a secure location. Concerns had not been picked up by the management team. This identified that although the service had a system of audits and checks to monitor the delivery of service, they were not robust enough to independently identify and address the shortfalls.

This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations.

Feedback from people, staff and our observations found further oversight was required in the monitoring both the quality of the service being delivered, and the experiences of people using it. To undertake this, further work was needed to improve / expand on the systems already in place to promote a more open proactive culture and supportive of providing people with person-centred care.

We found more could be done to actively involve people and staff in developing the service. One person said, "We have no official meetings," where they could feed back their views. Staff confirmed this; instead feedback was undertaken during one to one meetings with people and their responses recorded on a 'meeting' form. We looked at forms completed in September 2015 and May 2016. Where people had made statements saying what they would like to see more of / improvements in, for example the range and type of activities, 'the outcome needed and date planned' column had not been completed. Therefore the service did not demonstrate how they would be using the feedback as part of driving continuous improvements.

We recommend that the service seeks advice and guidance from a reputable source as to how they can develop a more empowering culture.

The provider was not always using the skills, experience and knowledge of their staff to support them in developing the service. Staff said where they had identified areas of the service that could be improved upon. However, the providers had not always listened or where they had listened could see no reason for change, as they had always done it that way. One staff member said, "We have staff meetings. They've

listened to a few things, like an extra member of staff on nights." Although they were unsure when it was going to be implemented. However staff also said that their requests for extra support during the day had not been acted on. All the staff we spoke with were motivated and committed to providing a good service. Some felt that the service was not always taking into account how the needs of people were changing and becoming more mentally frail. We found there was no analysis or consideration of the impact on the quality of care linked to the numbers and/or deployment of staff in the service.

People, relatives and visitors knew the management team and how to contact them. They were aware of the organisational structure of the service. The management structure consisted of the registered manager / provider, assistant manager, and team leader. The registered manager / provider split their time, working out of the office located in the service, and working from home. All the staff were aware how to contact the registered manager, if they needed to, and in their absence the assistant manager or team leader were around to provide any support.

The service had received complimentary feedback from stakeholders in their November 2015 surveys. In giving their overall impressions of the service, one health care professional said, "A very lovely place to come and see patients being looked after so well, very organised." Another had wrote, "Thank you, our job is made smooth by your considerate service."

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 were at risk because they were not provided with safe care and treatment. Regulation 12 (2) (a) (b) (e).
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems were not robust enough to independently identify shortfalls and take action to improve the service. Regulation 17 (1) (2) (a) (b) (c). (e)