Mars Care Services Limited

Tavey House

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 the 15 November 2016. Our visit was unannounced.

Tavey House provides accommodation for up to 12 people who require personal care and support. There were 12 people using the service at the time of our inspection including people living with dementia.

The service had a registered manager. 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. The care manager was in the process of applying to share the registered manager's post with the current registered manager.

There were not always enough suitably deployed members of staff on duty to meet the needs of the people using the service. This was because there were times when there were only two care workers on shift to support 12 people, three of whom needed two care workers to support them with their mobility.

Relatives we spoke with told us that their relatives were safe living at Tavey House and they were properly supported by the staff team. Staff members had received training on the safeguarding of adults and they knew what to do if they were concerned for someone.

Checks had been made when new staff members had been employed, though the reasons for leaving their previous employment had not always been explored.

People's needs had been assessed and the risks associated with their care and support had been assessed and managed.

Care plans had been developed for each person using the service and the staff team knew the needs of the people they were supporting well.

People were supported by a staff team with the right skills and knowledge. Staff members were supported through training and supervision and were aware of their responsibilities under the Mental Capacity Act 2005.

People had been involved in making day to day decisions about their care and support and the staff team understood their responsibilities with regard to gaining people's consent.

People received their medicines as prescribed though the recording of 'as and when required' medicines needed some clarification.

People's nutritional and dietary requirements had been assessed and a balanced diet was provided, with a

choice of meal at each mealtime. Monitoring records used to monitor people's food and fluid intake were not always completed accurately. This was addressed during our visit with the care manager implementing a new procedure for recording how much people had eaten that was more reliable than the one we had seen.

Staff meetings and meetings for the people using the service and their relatives had been held and surveys had been completed. This provided people with the opportunity to be involved in how the service was run.

The care workers we spoke with felt supported by the care manager and they felt able to speak with them if they wanted to raise any issues. They respected people's privacy though needed to be reminded of supporting people in a dignified way. This was done during our visit to the service.

People using the service had access to the required healthcare services and received ongoing healthcare support.

A complaints process was in place and people who were able to verbally communicate with us told us they knew who to talk to if they had a worry of any kind. Relatives knew who to talk to if they had a concern and were confident that anything raised would be dealt with appropriately.

Monitoring systems were in place to monitor the quality and safety of the service being provided though these were not always effective in identifying shortfalls, in particular, staff deployment.

We found the service was in breach of one 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 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 consistently safe.

There were not always enough staff suitably deployed to meet people's needs.

Recruitment processes had not always been followed.

Risks associated with people's care and support had been assessed.

People received their medicines in a safe way.

Is the service effective?

Requires Improvement

The service was not consistently effective.

A balanced and varied diet was provided but records relating to nutrition were not always completed accurately. People's mealtime experience varied because the staff team had little time to support people.

The staff team had the skills and knowledge to meet people's needs.

Where people lacked the capacity to make decisions, their plans of care showed that decisions had been made for them in their best interest. Staff members understood the principles of the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The staff team were caring though needed to be reminded about treating people in a dignified way.

People's privacy was respected.

The staff team knew the needs of the people they were supporting and they involved people in making day to day decisions about their care.

People's relatives were able to visit and were made welcome by the staff team.

Is the service responsive?

Good

The service was responsive.

The needs of the people using the service had been assessed and they and their relatives had been involved in deciding what care and support they needed.

Care plans were in place and the staff team knew the care and support needs of the people using the service.

People knew what to do if they were concerned or unhappy about anything and a formal complaints process was in place.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Monitoring systems were in place to check the quality of the service being provided. Staffing levels were not monitored and shortfalls were identified.

Staff members we spoke with felt supported by the care manager.

People using the service and their relatives had been given the opportunity to share their thoughts on how the service was run.

Tavey House

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 15 November 2016. Our visit was unannounced.

The inspection team consisted of two inspectors.

Before the inspection visit the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information within the PIR along with information we held about the service. This included notifications. Notifications tell us about important events which the service is required to tell us by law.

We contacted the commissioners of the service to obtain their views about the care provided. The commissioners had funding responsibility for some of the people using the service. We also contacted Healthwatch Leicestershire who are the local consumer champion for people using adult social care services to see if they had any feedback about the service.

At the time of our inspection there were 12 people using the service. We were able to speak with one of the people living there and four relatives of people living there. We also spoke with the care manager and three members of the staff team. The registered manager was absent from the service at the time of our visit.

We observed care and support being provided in the communal areas of the service. This was so that we could understand people's experiences. By observing the care received, we could determine whether or not people were comfortable with the support they were provided with.

We reviewed a range of records about people's care and how the service was managed. This included six people's plans of care. We also looked at associated documents including risk assessments and medicine

records. We looked at meeting records, two staff recruitment and training files and the quality assurance audits that the care manager had completed.

Requires Improvement

Is the service safe?

Our findings

At our last visit in November 2015, we identified that there were not always enough staff deployed to meet the care and support needs of the people using the service. Since that visit the provider had employed a cook and a cleaner however, shortfalls around staff deployment were again identified during this visit. The provider did not have a procedure for ensuring that people were consistently supported by sufficient numbers of staff.

When we arrived for our inspection there were two care workers supporting 12 people. One of those was responsible for administering people's medicines. An apprentice care worker made people drinks. Three of the people using the service required the support of two care workers with their mobility. This meant there were not enough staff to support those people should they require support at the same time, nor the other people using the service. One of the care workers told us, "I think we need more staff. One more would help. There always needs to be one member of staff in the lounge so it is quite difficult." A relative explained, "There's not always enough staff but they look after [relative] to the best of their ability." Another told us, "I doubt there is enough staff, I have said on occasion."

We saw one occasion when a person was told they would have to wait before they could be supported because the care workers were supporting another person. It also meant that whilst the two care workers supported that person, no care worker was available to support the other 11 people.

When we looked at the rotas we saw that there were three staff members on duty however, on a number of occasions only two care workers were rostered on, on an afternoon shift. This included the Saturday afternoon and the Sunday afternoon prior to our visit. This meant that there were only two care workers on shift to support the 12 people using the service with their meals, administer their medicines, answer the telephone and support them with their personal care.

The care manager told us they were available to support staff, but on the day of our inspection they were away from the home during the morning which showed they were not always available. We found that staffing numbers compromised the support people received when they had their lunch. Eight of the people using the service required their food intake monitoring and one required prompting to eat. However, care workers were unable to devote time to this because there were too busy. We saw that three people had barely touched their meals an hour after the meals were served because care workers were not available to spend time with them and support them.

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

One person using the service that we spoke with told us they felt safe living at Tavey House and felt safe with the care workers who supported them. They told us, "Oh yes, I feel safe. I find it fine here." Relatives we spoke with agreed with what they told us. One explained, "[relative] is safe here and that's the main thing." Another told us, "[relative] is definitely safe here."

Staff knew how to identify and respond to signs of abuse. They knew about the provider's procedures for reporting suspected or actual abuse. All staff had received training in safeguarding people from abuse or avoidable harm. Staff we spoke with demonstrated knowledge about the types of abuse recognised in the Health and Social Care Act. They knew about the provider's procedures for reporting concerns about abuse and said that they were confident that the care manager took their concerns seriously. Therefore this made them confident about raising concerns. They knew they could raise concerns directly with the local authority safeguarding team and the Care Quality Commission (CQC). One staff member told us, "We would tell a senior or [care manager] or the owners or CQC. I feel [care manager] would listen; she is very protective over [people using the service]."

The care manager was aware of their responsibilities for keeping people safe from avoidable harm. They knew the procedure to follow when a safeguarding concern had been raised with them.

Risks associated with people's care and support had been assessed when they had first moved into the service. People's care plans had risk assessments of activities associated with their personal care routines, for example when supporting people with their mobility. The risk assessments included information for care workers on how to support people safely and protect them from harm or injury. We did note that two care plans we looked at did not include risk assessments associated with how the person spent long periods seated in what looked like uncomfortable and potentially unsafe positions. We discussed these with the care manager who immediately took action to carry out risk assessments. Other risk assessments we looked at had been reviewed on a monthly basis. This was to make sure they continued to reflect the current risks associated with people's care and support.

We looked at the maintenance records kept by the care manager. Regular safety checks had been carried out on the environment and the equipment used for people's care and support. Checks had also been carried out on the hot water in the home to make sure it was at a safe temperature. Fire safety checks and fire evacuation drills had been carried out and the staff team were aware of the procedure to follow in the event of a fire taking place.

Personal emergency evacuation plans had been completed. These showed the staff team how each person using the service were to be assisted in the event of an emergency. We did note that not all of these were up to date. For example, one person's explained that they could walk independently when they actually needed assistance from the staff team. We brought this to the attention of the care manager who immediately amended the document.

We looked at two recruitment files and found that the provider's recruitment process had been followed to a point. References had been obtained and a check with the Disclosure and Barring Scheme (DBS) had been made. This check had been made prior to staff members commencing work at the service. A DBS check provides information as to whether someone is suitable to work at this type of service. Whilst these checks had been completed, we noted that the application forms did not include a full employment history. Where a staff member had left a person's employ, the reason for this had not been explored. Checking previous employment provides further assurances that people are suitable to work at the service. We discussed this with the care manager who took action to address these gaps.

Only senior care workers trained and skilled in medicines management supported people to have their medicines as prescribed by their GP. We looked at all 12 people's medicines and medicines administration records (MARs). We found that senior care workers consistently supported people to have their medicines at the right times or, in the case of pain relief, when they needed them.

Where people had been prescribed medicines for pain relief on a 'when required' basis, their care plans included protocols detailing when these medicines should be offered. These medicines are referred to as PRNs. We found that when PRNs were not administered, because they were not required, the MARs were marked 'NR'. This was not a recognised code for use on MARs and could easily be misinterpreted by paramedics or ambulance crew to mean that PRNs had been administered by a person with the initials 'NR'. This could mean that any treatment decisions by paramedics or ambulance crew could be based on inaccurate information. We discussed this with the care manager who explained that they would raise the matter with the organisation that advised her that 'NR' should be recorded.

Some people were prescribed topical creams. These were administered in line with the prescriber's directions. People's records included 'body maps' which showed where the creams had to be applied. This reduced the risk of creams being applied to the wrong area.

We observed people being given their medicines by a senior care worker. They referred to the person's MAR to ensure the correct medicine was given to the right person. The MAR was signed only after a person had been given their medicine. Medicines were given as prescribed. However, we saw that one person was given a medicine that should be given with food. We asked the senior care worker about this. They told us the person had "not long had their breakfast and would be having tea and biscuits soon." The person had their breakfast at least an hour and a half before but they did have tea and a biscuits shortly after the medicines. The medicines had not been given strictly in accordance with prescribing instructions.

Medicines were stored securely, and at the correct temperatures. Controlled drugs were stored and recorded correctly and regular checks had been carried out to ensure the records were accurate.

Senior care workers received the relevant training and their competence to support people with their medicines was regularly assessed by the care manager.

Requires Improvement

Is the service effective?

Our findings

Relatives we spoke with felt the staff team were appropriately trained and knowledgeable to meet the needs of the people using the service. One explained, "I assume they are well trained they are good enough at what they do" Another told us, "I think the majority of staff are, the rest I don't know."

The care manager explained that staff members had been provided with an induction into the service when they had first started work and relevant training had been completed. Staff members we spoke with and the training records we looked at confirmed this. One care worker explained, "I had an induction, I observed what was happening and observed other members of staff." Records showed us that appropriate training had been provided. This included training in moving and handling, basic food hygiene and infection control. Staff told us they felt supported through their training. One care worker told us, "I have had lots of training. Most of it is on line, I find it useful because you can go back and recap."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The DoLS require providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty

The care manager had an understanding of the MCA. They had made applications for DoLS authorisations in respect of people who lacked mental capacity to make their own decisions about their care and support. At the time of our visit there were four authorised DoLS in place. We found that people were being supported in line with those authorisations.

Mental capacity assessments had been carried out when people had been assessed as lacking the capacity to make a decision about their care or support. For example, when they decided whether to accept support with personal care. This assessment ensured that any decisions were made in people's best interest.

Care workers we spoke with had an awareness of the principles of the MCA. One care worker told us, "Not everyone has capacity so we make sure we do the best thing for them." They understood that where people had mental capacity to make decisions about their care and support, they had to obtain a person's consent. We saw this happen when, for example, staff discretely asked people if they wanted support with their personal care.

Records we saw of meetings that had been held, showed that these were used as an opportunity for people to make suggestions. For example, at a meeting on 17 October 2016 people were asked about what they'd like to do at Christmas. Relatives of people using the service were invited to a relatives' meetings every three months. These meetings gave relatives an opportunity to express their views. At the last meeting held, relatives spoke positively about the meals people had. Some expressed concerns about the laundry arrangements at Tavey House which sometimes resulted in people getting other people's clothes. The care manager had taken action to address people's concerns.

We asked one of the people using the service their thoughts on the meals served at Tavey House. They told us, "I enjoy my meals very much" we also overheard a person say after their lunch, "I thoroughly enjoyed it."

Menus were devised based on what people liked and choices were offered at each mealtime. The cook had access to information about people's dietary needs. People were shown the menu each day so that they could make a choice of what they wanted. Where alternatives were requested, these were accommodated.

During lunch time some people were supported to sit at the dining tables, whilst others had their lunch whilst sat in an easy chair. The dining tables were set with table cloths, place mats and napkins and condiments such as salt and pepper were offered.

One person's care plan stated that the person should be 'prompted' to eat because they were at risk of malnutrition. However, the care plan did not state how the person should be prompted. During the lunch time period when people had their meals, we saw that on several occasions two care workers said to the person things like, "come on eat up", "come on keep eating", "try a little bit more" and "come on, is it [the meal] nice?" and, "gonna try a bit more dinner before having your pudding?." By that time, the person had had their dinner in front of them for 45 minutes and had eaten less than half of it. Another person who ate half of their dinner expressed they hadn't enjoyed it. A care worker said, "Didn't you like your dinner, was it awful?" without asking if the person would prefer something else to eat. We found that two care workers were too few to provide the support people needed at lunchtime. For example, people who appeared to be struggling with cutting food items were not always supported promptly and people who required prompting had only cursory and passing prompts rather than support from a care worker who spent more time with them.

The provider had monitoring forms for staff to record how much people had eaten. This was expressed in terms of a quarter, half, three quarters or all of their meal. An instruction on the form was that the form be completed when a plated meal was removed and taken away. This did not happen on the day of our inspection. We asked a care worker how they remembered who had eaten how much and they replied, "I know, it's in my head". We then heard them comment that a person had eaten three-quarters of their meal, but we had been sat close to the person and it was evident they'd had no more than half their meal. We discussed our observations with the care manager. They told us that they would immediately implement a new procedure for recording how much people had eaten that was more reliable than what we had seen. In future, plates would be returned individually to the kitchen where a record would immediately be made.

Another form of monitoring people's nutrition was to weigh them and monitor unplanned weight loss or weight gain. Forms were used to record a persons' weight but the design of the form omitted a space to record reasons for increase or decrease or what extent of weight loss or gain should trigger an action, for example a referral to a dietician. This made the monitoring forms ineffective as a monitoring tool. We saw one person's records that showed a 2.5 kilogram weight loss in the space of six weeks but no reasons why that had occurred or if any action was required. This was one of the people who had left half their lunch. The weighing records and records of food intake were not being coordinated.

For people at risk of dehydration this again was being monitored. We checked the charts and found that drinks were being recorded and the total amount of fluids taken each day were being totalled. We noted in the records we looked at that the recommended daily fluid intake for each person had not been identified. A care worker told us, "I think it's between one and one and a half litres each day." By having the recommended daily fluid intake recorded, care workers could be sure that they were providing the correct amount of fluids each day in order to keep people well.

We saw in people's care records that they had been supported to access health services. This included accessing support from their GP, chiropodists and community nurses. Visits were recorded in people's records and this confirmed to us that they were able to see a healthcare professional when they wanted.

Requires Improvement

Is the service caring?

Our findings

A person using the service told us that the staff team were kind. They told us, "The staff are nice and kind. We have a bit of a laugh with them." We heard another person say to a care worker, "You do look after me so well." Relatives agreed with what they told us. One explained, "The staff are very kind and very caring." Another told us, "The staff are lovely and very helpful."

We observed support being provided throughout our visit. Staff showed a good understanding of people's needs. We saw examples of staff supporting people in a caring and compassionate manner. This included one person who was supported to use the bathroom in a discreet manner and another person who was reassured when they felt anxious. However, we also saw a number of exceptions to this. For example, at breakfast time a care worker was observed assisting a person with their breakfast, though rather than sitting next to them to assist them this was done standing over them. Two staff regularly referred to a person by a shortened version of their name which the care manager told us must not happen. We saw two care workers who regularly stood and leaned towards people when talking with them instead of speaking with people at their eye level. We saw a care worker support a person to get into a more comfortable position when they were seated, but their language was not dignified. They asked the person, "Push your bum back." Another care worker however showed more tact. The support a person received at lunchtime with their meal was at times punctuated by undignified language.

A care worker explained to us that a member of the staff team was required to stay in the lounge area at all times to keep people safe. We saw that this was happening, however rather than taking the opportunity to interact with the people using the service, they tended to simply stand or sit around. We observed one care worker sit on a table next to one of the people using the service for eight minutes within that time only two short interactions occurred. We discussed our observations with the care manager who assured us that this was not normal practice and the staff team would be reminded of the importance of interacting with the people using the service.

We saw the care workers respecting people's privacy and they gave us examples of how they ensured people's privacy and dignity was respected. One care worker explained, "I always shut the door when I'm assisting someone to the toilet and I cover them with a towel when I'm helping them with their personal care."

The staff team at Tavey House had recently gained the 'Respect 4 Dignity Award' from Leicestershire County Council (LCC). To gain this award the provider had to demonstrate to the LCC how they delivered a service that maintained the dignity and respect of the people using the service. This they did and they received their award in May 2016. However, some of our observations showed that staff were not consistently acting in ways compatible with the award.

People using the service had, whenever possible, been involved in making day to day decisions about their care and support. A care worker told us, "We always help people to make decisions and choices. For example, when we help people get up, we get clothes out for them and get them to decide what they want

to wear."

We looked at people's care plans to see if they included details about their personal preferences or their likes or dislikes. We saw that whilst some did others could have been more personalised. We discussed this with the care manager and it was evident that they were in the process of updating people's personal information. This would make sure that the staff team had the information they needed to be able to offer more person centred care.

Relatives told us that there were no restrictions on visiting times except at meal times and that they were always made welcome by the staff team. One relative told us, "We can visit at any time and we are always made welcome." Another explained, "We can visit anytime apart from mealtimes."

Good

Is the service responsive?

Our findings

Relatives told us they and their family member had been involved in deciding what care and support they needed. One relative told us, "We were involved in deciding what help [relative] needed at the beginning."

People's care and support needs had been assessed prior to them moving into the service. This was so that the care manager could assess whether the person's needs could be properly met by the staff team working at the service. From the initial assessment, a care plan had been developed.

We looked at six people's care plans to determine whether they reflected the care and support the people were receiving. Whilst the majority did, one did not. We noted that one person's care plan did not reflect their current dependency on the staff team. For example, part of their care plan stated that they required assistance from one care worker, yet in another section it stated that they required assistance from two care workers. Within their continence plan, one side of the plan stated 'now back to being independent and if support is needed it is by one staff' yet on the other side of the plan, it stated 'requires assistance from two care workers'. This was immediately addressed by the care manager and the documentation was updated. Whilst it was evident that this care plan was not up to date or accurate, the care workers we spoke with were aware of the persons care and support needs. Care workers we spoke with were familiar with the contents of people's care plans and they demonstrated knowledge of people's individual needs and abilities.

People's care plans had been reviewed each month or sooner if changes to their health and welfare had been identified. Where changes in people's health had occurred, the appropriate action had been taken. This included for one person, contacting their GP when they had become unwell. This meant that there were arrangements in place to regularly assess and review people's care. Not all of the care plans showed evidence that they had been reviewed either with the people themselves or with someone who knew them well.

The majority of care plans seen were 'person centred' because they contained information about people's life history, their preferences and how they wanted to be supported. Those that didn't were in the process of being updated so that they reflected this person centred information.

Whilst people's care plans were centred on their needs, care workers were not always able to support people to the extent required, because there were not enough of them.

People's care plans included information about their interests. Most people liked to watch television or listen to radio programmes and music. They were supported with activities such as armchair exercises and games to maintain what flexibility and dexterity they had. They played games which supported them to engage with other people using the service. A person told us, "We have a laugh together and we get on well." Activities included a mix of social activities and one-to-one time with a care worker when they played games that exercised their dexterity. A person using the service told us they enjoyed having conversations with people. We saw an apprentice care worker do this and from the reactions we saw from people they clearly enjoyed it.

People using the service and their relatives or representatives knew who to talk with if they had a concern of any kind. A relative told us, "I would talk to the day staff, but if they couldn't deal with it, I would talk to [care manager]. You can always email them as well, they are very approachable." People had access to the provider's complaints procedure a copy of which was displayed in the foyer. The provider had received no complaints since our last inspection in October 2015.

Requires Improvement

Is the service well-led?

Our findings

The care manager understood their responsibilities and kept the CQC informed of events at the service, such as deaths, accidents and incidents. This was important because it meant the CQC could monitor the service. They had a clear vision of what they wanted to improve at the service which they told us about in the Provider Information Return they sent us before the inspection visit. They told us that they had increased their staffing levels since our last visit, however these were still not always sufficient to meet people's care and support needs. They require the provider's support to achieve these improvements.

The care manager had systems for monitoring the quality of the service. A key part of this was an annual satisfaction survey which included questions about people's experience of the service. The responses to the survey were with the provider for analysis at the time of our inspection. Other monitoring included observations of staff practice, supervisions, and audits of care records. After we discussed some of our observations of how staff supported people with the care manager, they told us they would carry out more observations to support staff to improve areas of their practice. Not all of the care records we saw were accurate. These included the care plan and the personal emergency evacuation plan belonging to a person whose mobility needs had changed.

Regular audits to monitor the environment and the equipment used to maintain people's safety were also carried out.

The care manager's monitoring systems had not identified the concerns raised during our visit with regard to staff deployment at the service. For example having two care workers rostered on to provide personal care and support to 12 people, including the administration of people's medicines and the serving of people's meals was not sufficient. They acknowledged this and following our visit they confirmed more support was being offered at lunch time and they were actively trying to recruit more members of staff.

People using the service and their relatives had opportunities to be involved in discussions about developing the service. These included relatives and residents meetings which the care manager used to invite people's suggestions and ideas. We saw from records of meetings that relatives had made suggestions about mealtimes, activities and raised concerns about the laundry arrangements at Tavey House. The care manager had addressed people's concerns and implemented improvements.

The staff team were supported to raise concerns about what they felt was poor practice. This was through policies and incident reporting procedures. They were also supported to raise any concerns during one to one supervision meetings and staff meetings. Incident reports we looked at contained evidence that the incidents had been investigated and actions taken to reduce the risk of similar incidents happening again. This was through the reviewing and reassessing of risk assessments. Incident reports were also discussed at staff meetings and used as a tool to drive improvement.

Staff members we spoke with told us they felt supported by the care manager and felt able to speak to them if they had any concerns or suggestions of any kind. One staff member told us, "I do feel supported; there is

always someone around to talk to if we have a concern."

The care manager promoted caring values through policies and reinforced those values at staff meetings and one to one supervision meetings with staff. They did this on the day of our inspection after we discussed some of our observations with them.

People using the service and relatives knew who the care manager was. They told us, "[Care manager] is approachable; we can share our views with them." Another told us, "We can talk to the manager and we are kept informed of things that happen."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Sufficient numbers of staff. There were insufficient numbers of staff to support the people using the service.