

HC-One Oval Limited

# The Red House Care Home

## Inspection report

Bury Road  
Ramsey  
Huntingdon  
Cambridgeshire  
PE26 1NA

Tel: 01487898106

Date of inspection visit:  
18 January 2018

Date of publication:  
23 February 2018

## 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

The Red House Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The Red House Care Home accommodates up to 60 people across two buildings. The main building accommodates 48 people who may require nursing care and some of whom may be living with dementia. There is a further building in the grounds that accommodates 12 people who have personal care needs. Each building provides accommodation over two floors.

This comprehensive inspection took place on 18 January 2018 and was unannounced. At the time of this inspection care and support was provided to 57 people. This was the first inspection since HC – One Oval Limited was registered as the provider of this service.

There was a registered manager in post. '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.'

There was not enough staff to meet the needs of people who used the service. People did not always receive the support that they needed in a timely way and staff said that they felt rushed.

Care plans did not consistently contain details about people's care and support needs. Whilst risks to people had been identified, the guidance available to staff in relation to managing these risks was limited.

Staff had been safely recruited and received on going training. However they had not all received supervision in line with the provider's policy.

Suitable arrangements were in place to help safeguard people from harm. Staff knew what to do if a person made an allegation they were being harmed or if they had any concerns about anyone's safety.

People were supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible.

Staff were friendly and respectful and there was a good rapport between staff and people who used the service. Although, there was a lack of activities indoors for people to take part in, this could lead to people who chose to stay in their rooms becoming isolated. There was an opportunity for people to have days out.

Health and safety records showed checks were undertaken regularly to ensure that equipment was kept safe and in good working order.

The service was clean and there were arrangements in place to ensure that staff wore protective clothing such as disposable gloves and aprons. This reduced the risk of cross infection.

People were on the whole happy with the choices, quality and quantity of the meals and snacks available. People had access to health care professionals and received support with their health care needs in a timely manner.

Systems were in place for receiving and responding to complaints. A number of compliments had been received from relatives.

Systems were in place to monitor and audit the quality of the service provided but these were not always effective required actions had not been taken.

As a result of our findings we found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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?

The service was not always safe

There were not enough staff to ensure that people remained safe and received their care in a timely manner.

Risk assessments did not provide full information to ensure that staff knew how to reduce risks to people.

Staff understood their roles and responsibilities in ensuring that people were protected from harm.

**Requires Improvement** ●

### Is the service effective?

The service was not always effective

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

People had choice over their meals and were being provided with a specialist diet where appropriate.

People received the support with all their healthcare needs.

**Requires Improvement** ●

### Is the service caring?

The service was not always caring

Staff did not always have the time to spend talking with people.

People did not always receive their care at a time of their choosing

People spoke positively of the kindness and caring attitude of the staff.

**Requires Improvement** ●

### Is the service responsive?

The service was not always responsive

There was a lack of activities for people, particularly for people who spent the majority of time in their room.

**Requires Improvement** ●

Not all people's care records contained enough information to guide staff on the care and support that they required.

End of life care was discussed with people to ensure their wishes were known.

### **Is the service well-led?**

The service was not always well led

Systems were in place to monitor and assess the quality of the service. However we noted these were not effective.

People, relatives and staff were involved in the running of the service.

The registered manager was aware of the need to notify CQC of any incidents or safeguarding concerns within the service.

**Requires Improvement** 

# The Red House Care 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 comprehensive inspection took place on 18 January 2018 and was unannounced. The inspection was undertaken by two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. At the time of this inspection care and support was provided to 57 people.

Prior to our inspection we reviewed the notifications received by the Care Quality Commission (CQC) and other information we hold about the service. A notification is information about important events which the service is required to send us by law. We also contacted the local authority to ask for their views about the service.

The provider completed a provider information return (PIR) and sent this to us before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used information from the PIR to assist us with the planning of the inspection.

We spoke with 13 people who lived at the service and four relatives. We observed how staff interacted with people who lived at the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to complex health needs.

We spoke with a registered manager (representative of the provider), deputy manager, a nurse, a senior carer, four care workers, and two staff who worked in the kitchen. We also spoke with a GP that was visiting the service.

We looked at records in relation to five people's care including medicines' administration records. We

looked at records relating to the management of risk, minutes of meetings, staff recruitment and training, and systems for monitoring the quality of the service.

# Is the service safe?

## Our findings

There were not enough staff employed to ensure that people were safe.

All staff spoken with told us there were not enough members of staff to care for the people living in the home. One member of staff said, "There are not enough staff. We get told off for not doing the paperwork, but we are on shift [looking after people]. I don't think people [living in the home] are getting what they should. Sometimes it's just a face, hands and bottom, not a proper wash." Another member of staff told us that, "Not everyone is able to have a bath every week especially if they require two staff to support them. There is just not enough time." A third member of staff said, "Seniors [senior staff who are responsible for the updating of care plans for people receiving residential care] are included in the numbers and have no time to write or tell people [other staff] about changes in people's care plans or care."

One staff member told us that a person recently had to attend the accident and emergency department at the local hospital in the evening alone as there were not sufficient staff to accompany them. We were informed that this was not an isolated incident and that if families weren't available to support people, they often had to go to hospital alone. However the registered manager stated after receipt of their draft report that the service is part of a pilot project called 'the red bag' scheme. This enables someone to go into hospital with all the necessary paperwork, clothes and other valuable information in a pen portrait of the person to aid paramedics, ambulance staff and those receiving the person in hospital with the information to provide them with care and support.

Another member of staff told us, "If a staff member goes off sick in the house then a member of staff from the main home are asked to go over to cover. This then leaves the main house short on staff. It's so difficult and residents [people who use the service] deserve better. It's not right but I love my job and do the best I can."

One person had been given their breakfast whilst they were still in bed. They had gone back to sleep and their breakfast had gone cold. We went to find a member of staff who told us, "We don't have the time to sit and encourage people to eat. They are independent but need encouragement to get going. It's so difficult as other people need support to wash and dress before they have their breakfast as is their choice."

We found that staff were constantly on the move trying to meet each person's needs. Staff were attending to each person as quickly as they could whilst trying to give them time and not rushing them. They responded to call bells but they did not always have the time to support the person immediately. The staff would explain to the person that they would return as soon as they could when they had finished supporting the other person.

A staff member said, "Sometimes you can be left on your own (in a section of the service). Most days we are running around trying to find someone [staff] to help you." A second member of staff added, "Most of the time its ok, but we find it hard if people have appointments or staff are off the floor. (Meaning away from the main communal areas)."



One relative told us, "The staff are good and try to respond quickly, but there just isn't enough of them."

The service did have a dependency tool which was used to assess the numbers of staff required work in the service. Although the dependency tool was used to calculate the numbers of staff required to work, we found that there were not enough staff to meet people's needs.

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

People were at risk because care records were not always completed or up to date. We found that risks to people had been recognised but risk assessments had not always been completed, or where they had been completed they had not always been updated.

We found that one person had been assessed as being at risk of depression, There was no information provided to staff to inform them of actions that they could take to try to reduce the person becoming depressed. We saw that one person who used a wheelchair did not have a risk assessment in place. There was no information on how staff should keep the person safe whilst they were in their wheelchair. Risk assessments had not been reviewed on a regular basis. We saw that risk assessments for one person had last been reviewed six months ago but that their risks had changed.

We spoke with the nurse who told us that medication could take up to 3 hours to administer. A staff member who undertook the medicine administration for people who were receiving residential care told us, "This [medicines administration] can sometimes take a little time due to the number of people who receive medication in the morning."

The nurse described to us the timing of the administration of medicines and the recording of those times. They told us that people who required pain relief or a specific timed medicine [a medicine that requires a specific gap between doses] received their medication first. However the recording sheet did not allow them to record the exact time that the medicines were administered. The recording chart stated 'breakfast, lunch, teatime, evening'. This meant that there was a risk that there the person may not receive their next medicine at the required time.

Not everyone we spoke with was satisfied with how their prescribed medicines were managed. One person said, "I've had [health condition] for so long now I know my own body best and there are times when I need a dose earlier than I get it."

We found that people were given time to swallow their medicine and the nurse checked with people how they would like to take it. They asked the person, "How do you take your tablets, one at a time or all together?"

Medicines were stored safely and the amount in stock tallied with the records. Staff who administered medicines were trained and assessed to make sure they had the required skills and knowledge. Medicines administered were recorded in people's Medicine Administration Records. People's medication was reviewed regularly with their GP. Monthly audits of medicines management were carried out with actions taken to follow up any issues found.

Staff we spoke with were aware of their roles and responsibilities in relation to safeguarding. Staff received training and were able to describe the types of harm that people might experience. They also told us about the actions they would take in response to any event where a person was at risk of harm. This included

reporting the concerns to the management team of the service and to external agencies, which included the local safeguarding team. A member of care staff said, "There may be a change in a person's behaviour, they may have a bruise with no cause." Another member of care staff gave a similar response and added that people may become quiet and withdrawn or may not eat. The provider had safeguarding and whistle blowing policies and staff were actively encouraged to challenge poor practice and raise concerns with senior staff. One member of staff told us, "I would have no hesitation in reporting poor practice and have confidence that it will be dealt with."

Appropriate recruitment checks had been completed to ensure that suitable staff were employed. Information received prior to a person starting employment included a criminal record check (DBS), checks of qualifications, identity and references.

Staff said that incidents and accidents were always recorded, investigated and dealt with. We saw where themes were identified advice was sought from relevant health professionals to support people and the service. For example, we saw that one person had had several falls. The service had sought advice from an occupational therapist to explore ways of reducing the frequent falls. One staff member said, "We complete accident and injury forms. One person who fell was referred to the O.T. [occupational therapy service]. We now help [the person] with two staff walking [the person] a little bit further each time to encourage them. [Name of person] has a pressure mat [in place] after getting out of bed and falling."

There were systems in place to help promote infection control. These included cleaning regimes and schedules and training for staff. Staff had a good awareness of what actions to take should they have a sharps injury and who to inform. They were aware of how to dispose of clinical waste and how and when to use personal protective equipment such as gloves, aprons and hand gel. We saw that staff used gloves and wore aprons appropriately and the home was clean and fresh on the day of our inspection.

There were a range of checks undertaken routinely to ensure that the service was safe. These included such areas as water temperature checks, safety checks on bedrails, and fire checks. This showed us that the registered manager and provider were committed to providing a safe service.

## Is the service effective?

### Our findings

There was an induction programme for new members of staff, and whilst on induction staff received a range of training. Staff who were on induction shadowed staff and were not included in the staff numbers. However, we were told that a member of staff who commenced in November and was working nights had not yet received an induction. The representative of the provider told us that they would ensure that the person would continue to work under supervision until they had completed their induction.

The registered manager maintained a record of each staff member's annual training requirements and organised a range of courses to meet their needs. Staff we spoke with felt they had adequate training to meet the needs of the people they cared for. Staff told us that the registered manager regularly 'worked alongside' the staff when they were providing care and support. This ensured that staff implemented their training and ensured they delivered good quality care to people. As a result of these checks staff knew what was expected of them.

Not all staff had received supervision or an appraisal in line with the provider's policy. The provider's policy stated that 'We require managers to undertake regular supervisions (a minimum of 6 per year)' and 'all employees should have one formal appraisal each year'. One staff member said, "I have been here [eight months] but haven't had supervision or an appraisal, but some people [staff] do have them." Another person told us, "I have had supervision in the past but not in the last six months. I feel supported by the care workers and can always ask for support if I am not sure of anything. [Name of deputy manager] is very supportive you can always ask them for help."

We observed the lunchtime meal in two dining rooms. We found that some people who required assistance to get to the table waited over 40 minutes before they were served. Staff told us they needed to start bringing people to the tables early as most required assistance. They then served those people who chose to eat in their rooms were served first.

The lunchtime was relaxed and peaceful. Staff asked people if they needed assistance. We observed a staff member asking one person, "Do you need help to cut up your food." As the person had limited communication we saw that the staff member interpreted the smile from the person as an acceptance of consent. The assistance provided was in a manner that was both respectful and involved the person to allow them to be independent as they were able.

People's individual dietary needs were catered for and were known by the Chef. People who had been assessed as being at risk of malnutrition were provided with a fortified diet to increase their caloric intake and to encourage weight gain.

People's day to day health needs were met in a timely way by staff and they had access to health and social care professionals when necessary. One person told us, "I see the chiropodist who sorts out my feet." Another person who had recently been admitted said, "The staff are working hard to get me registered with a GP so I could get the meds I need before I run out."

A visiting GP said, "I am really happy with the [staff] team who look after the patients [people living in the home]. The carers [staff] are very kind and I have found them to be excellent. I have received no negative feedback from any of the people who reside here. Staff are helpful. We have a good working relationship with the managers and don't hesitate to speak and they listen." The GP confirmed that staff request them appropriately and through the correct channels. Information is ready and completed prior to a visit if it has been requested. For example, if recordings of temperature, pulse and respirations have been asked for.

People lived in a well maintained home. It was warm, homely and cleanly decorated. However, there was no signage to assist people in finding their way around. There were handrails and other adaptations which helped people to maintain their independence. Many of the people were living with dementia and the environment had been not been decorated and furnished in accordance with current best practice, to assist people to maintain their independence.

Information about the menu and activities was only provided in a written format so not everyone would be able to see what was happening and what was on the menu. Everyone had access to safe and secure garden areas.

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. The service held an appropriate MCA policy and staff had been provided with training in this legislation.

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 service had applied for some people to have potentially restrictive care plans authorised.

Staff understood about DoLS. One member of staff said, "DoLS is to protect residents and we have best interest information in their care plans. Some people have got bedrails, some use their own toiletries and all of that is in their files." However, where a person had been identified as having limited understanding about why they needed to take their medication for behaviour that may be challenging, there was no written information on how to ensure those needs were met in the person's best interest.

## Is the service caring?

### Our findings

People told us they felt they were treated with respect and dignity. One person told us, "I am looked look after very well. I'm fed and kept warm." Another person said, "Staff had taken time to know and understand my needs." A third person said, "They have been really good at settling me in, the handyman is fitting my TV on a wall bracket and they helped me to get my Sky box installed. I even went to get a haircut this morning with the hairdresser here which was a treat." A relative told us, "Staff are unfailingly kind and patient with [family member], they were very careful washing them. Staff respects [family members] communication needs and work to make sure they understand their needs."

When staff started on the shift they told us that they did not receive a handover. This meant that staff may not always have up-to-date information about people. However the registered manager stated that handovers take place three times a day. Not all care plans contained full information about people. Peoples preferences. Personal histories and backgrounds had not always been recorded. This meant that staff did not always know the person that they were caring for.

During a period of observation we noted most people had good interactions with staff. However, for one person the interaction with staff was very limited. This person sat quietly in their chair. Staff made no attempt to speak or interact with them. Staff encouraged people as they assisted them to transfer from chair to wheelchair and back and explained what they were doing and how they could assist themselves. No-one was hurried and staff spoke quietly to people to provide as much privacy as possible.

Whilst staff demonstrated to us they cared about people and worked to promote their wellbeing we found there were aspects of people's well-being which were compromised. Staff told us that people were not always able to have a bath when they wanted one. This was because some people required two staff to support them. Staff told us there was not always two staff available. Another member of staff said, "You have to try to get everything done. It's sad because you don't have the time to do things in the right way and spend more time talking with the residents."

Staff told us that they provided as much choice as possible for people. Choices included the food people choose to eat, what they want to wear. However, staff said that if people wanted to go out and required a staff member to accompany them that would not usually be possible.

During our inspection, staff on numerous occasions demonstrated their caring and sensitive approach to their work. For example, when one person became anxious a member of staff stopped what they were doing and sat with the person holding their hand and talking to them, until the person appeared less anxious. However, we saw at other times, when rushed, staff became task focused. For example, during lunch service one person who needed support from two staff to move safely asked for assistance with personal care. Whilst staff responded to the person's request they did so without speaking with the person.

Staff demonstrated good skills at communicating with people. One staff member explained to us, "When a person is hard of hearing, you have to get close to them and raise your voice. I would kneel down so I am eye level to them." We observed that when staff communicated with people they listened and gave people the

time and opportunity to respond. We observed one staff member supporting a person who was hard of hearing during lunch. The staff member demonstrated a respectful attitude towards the person by positioning themselves in such a way that they could communicate with the person at all times.

People were cared for by staff who were patient, kind and caring in the way they supported people. Staff ensured people received a guiding hand in the support they provided. For example, we saw one staff member bringing someone in their wheelchair through a doorway into the lounge area. They ensured they put their hand on the person's shoulder and reminded them to keep their arms in, so they didn't bang them on the doorway. We noted that people smiled when staff spoke with them. One person said, "Oh yes, they are lovely girls, always smiling and laughing." A relative told us, "The staff are tremendously patient and very kind." Another said, "The staff are very caring, we can't thank them enough for the care they provide."

Staff told us things such as "This is a resident's home. We like it to be a happy home," and "This is the friendliest home I've been [worked] in." They showed us the house motto of 'Our home runs on love and laughter'. Another staff member said, "We come and work in their home. We try and keep it a comfortable home. No-one is ever got up unless they want to. If they continue (to not get up) we would discuss to check if there were any problems."

People looked clean and tidy and one person told us they had clean clothes every day which they chose. The same person told us that they had issues around anxiety and the staff had provided them with a book of pictures and names of the staff in the home. The person said this had really helped them at the times they did become anxious.

Staff were able to explain how to protect people's privacy and dignity when providing personal care. One member of staff said, "I always make sure that the door is closed when I am undertaking personal care. I always get the person to do as much for themselves as possible. This helps keep their independence." They also told us, and we saw, that confidential information about people, such as care plans, risk assessments and health information was kept secure.

Information about local advocacy services were available to support people if they required assistance. However, staff told us that there was no one in the service who currently required support from an advocate. Advocates are people who are independent of the service and who support people to raise and communicate their wishes.

## Is the service responsive?

### Our findings

Although some care plans were person-centred and outlined people's preferences, interests and wishes others were not. The quality of the information varied. Some contained full information to show how people were to be supported and cared for whilst others contained very brief information.

The deputy manager was the only nurse that was permanently working on days. All other nurses employed to work during the day were from an agency. Nurses were responsible for administering medication to people who received nursing care and for updating care plans. Some of the agency nurses were regular and knew people well. However, not all agency nurses were able to update care plans as they didn't know people in the home. This meant that people records were not always fully up to date.

The deputy manager told us that a full review of people's care plans was being undertaken. They said that, "They were not where we need them to be." They also informed us that new paperwork from the new provider was to be introduced in the next month.

The care plan for one person with complex needs did not state how staff what care the person required. Under the heading 'What support does the person need', the comments were 'Staff to report any changes to senior staff and GP'. This meant that staff did not have information about how to care for this person. The deputy manager informed us that staff would be given additional training and would begin to take on more responsibility for specific areas of care planning. The deputy manager said they will work alongside staff to ensure that care plans fully reflected people's care and support needs.

Staff did not always provide people with the support they needed when they asked of it. When people activated their call bells, staff went to the person very quickly. However, they turned the bell off and told people that they would return to them when they had time. We noted that this could take up to 20 minutes

There were mixed views from people and their relatives about the activities available at the service. One person said, "I know there are activities available but they are not very challenging." Another person told, "There are activities but they are limited. The activities person is doing maintenance at the moment." The deputy manager confirmed this was the case.

The activities were detailed on a board in the main dining room/ lounge. They included jigsaws, skittles, crafts and a beauty morning. A church service took place every week. On the morning of the inspection an external facilitator was providing chair based exercises to 12 people. They were lots of smiles and some chatter during the session. The afternoon session of 'Guess the picture' did not take place due to staff not being available.

Various activities had taken place in the community One staff member said, "We have fetes and a lot of people from the local area come. We have some entertainment come in but we don't go out very much." Although we were told that people had been a trip to a 1940's day in the town of Ramsey, a trip to Hunstanton, a trip to the local garden centres and a trip to the local barracks. As the home does not have its

own transport, it utilises the community bus when available for trips into the community.

Throughout the inspection, the majority of people spent their day sitting in the lounge with little stimulation. Other people who chose to spend most of their time in their room received little one to one interaction from staff, other than for regular checks. Staff demonstrated to us that they had the skills to interact with people, but their interactions were mostly restricted to undertaking tasks as there was no time for them to undertake activities. Staff all said they would like to spend more time with people.

We were told that the activity coordinator who should provide activities was undertaking the duties of the maintenance person. As this currently vacant. Although there were two other part time staff who provided some activities but, they were not working on the day of our inspection.

Complaints and comments were listened to by the registered manager and responded to in a way that demonstrated to people they were taken seriously. We read feedback from one person who was unhappy with some aspects of their care. The registered manager had met with the person to discuss this and they had worked together to agree a plan of care for the person. Complaints information was displayed in the home and was also provided to people in the information booklet that they were given when they moved into the service. Relatives told us they had made complaints in the past, but this was before the current registered manager took over and the consensus of opinion was that things had improved. There were a number of compliments.

Staff were clear about how to help a person living in the home to make a complaint. One staff member said, "If a resident wanted to complain I would speak to the senior [member of staff] and tell them." Another member of staff said, "I would always tell the management if somebody wasn't happy. We can't change things and make them better if people don't tell us about their problem."

Staff told us that where appropriate people's wishes around end of life care were discussed and recorded. They told us they would work closely with the local palliative care team as appropriate to ensure people's care was managed effectively. There were no people receiving end of life support at the time of our inspection.



## Is the service well-led?

### Our findings

The service had a registered manager in post. 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 and associated Regulations about how the service is run.

The registered manager was aware of their statutory duties in relation to their registration with CQC. As part of registration registered managers should notify us of all safeguarding incidents or serious injuries to people. We found that relevant notifications had been submitted to us. In addition, the registered manager had worked closely with external stakeholders to look at incidents and to learn from these and improve the service. Incidents were monitored and discussed at senior management level and any learning was cascaded to staff.

Staff had different views about the leadership of the service. One member of staff said that "Managers are available and come around [the home]. [Name of registered manager] is here before we are and stays until late and the door is always open." The staff member continued that the management had been very supportive with them during a personal difficult time. Another member of staff said, "The [registered] manager's door in the home was always open." They went on to say the management team were available [where possible].

We were told that if a member of staff called in sick the management 'phoned around to try and cover the gap'. Staff said they felt under pressure to work even if they were sick as they felt "frightened and people [management] don't believe you are sick."

The registered manager carried out monthly audits on the quality of the service provided. Audits covered a number of areas including medication, health and safety, environment, and care plans. The regional manager had oversight of the home and made regular visits to monitor the care provided in the home. We found they carried out monthly visits when they reviewed people's care plans and spoke to staff and people who used the service. The last visit was undertaken in early January. It had identified that care plans required updating to reflect people's current needs. They had also noted the number of vacancy hours for both care staff and nurses. However there was no mention of the impact that this had in people's care. There was no evidence to show that the issues with dependency tool had been addressed.

Staff told us that they had not received supervision for some time, although they did tell us that they could approach the management team at any time if they had any concerns.

There were regular staff meetings. These were an opportunity to keep them informed of any operational changes. They also gave an opportunity for staff to voice their opinions or concerns regarding any changes. A staff member told us, "It's important we get to the meetings where possible because it keeps us updated about things. If we can't make it minutes are available so we don't miss anything."

There were regular management meetings held between the registered manager and the heads of each department in order to discuss such issues as recruitment, the performance of the service and any matters arising.

Feedback was sought from people who lived at the home in a variety of ways. These included regular residents and relative meetings being held and satisfaction surveys being sent out to people, their relatives and stakeholders. Responses from surveys had been analysed and actions had been put in place to address issues that had been identified. Where the registered manager received comments from relatives or people they addressed these straight away. A relative told us, "We do attend the relatives' meetings and we feel that we are being listened to." Another relative said, "We have been kept well informed about the changes that have been taking place. Especially in relation to the new provider take over." A third relative told us they had recently attended one meeting where the registered manager had spoken about the plans for the service and had tried to assure people that changes would be made to make things better." The action plan stated that the registered manager has identified the need to set up the dates for these meetings for the coming year.

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
Treatment of disease, disorder or injury	The registered person had failed to ensure that sufficient numbers of suitably qualified, competent and experienced persons were being deployed effectively.
	Regulation 18 (1)