Reside Care Homes Limited

Reside at Stour Road

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on the 11 December 2017 and was unannounced. It continued on the 12 and 28 December 2017 and was announced. Reside at Stour 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 care home accommodates 20 people in one adapted building and provides care to older people some of whom are living with a dementia. At the time of our inspection 16 people were using the service. Accommodation is over two floors and access to the first floor is by stairs or a lift. There is a communal lounge and dining area which provides level access into a secure garden.

The home had been without a registered manager in post since October 2017 but a manager had been appointed and was starting employment in January 2018. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People had their risks assessed and reviewed monthly. Actions put in place to minimise identified risk were not always being followed. Two people had a high risk of malnutrition and actions had been put in place to minimise the risk of continued weight loss which included staff completing a food and fluid diary and monthly weights being recorded. Risk reviews and monitoring processes had not identified that some actions were not happening or not being effective which meant people were not being protected from avoidable harm. Health and safety audits had been completed but priority actions had not been completed in a timely way.

Prior to admission people were involved in an assessment of their needs and choices and this information was used to create care and support plans. Information in care and support plans was not always accurate in describing the care and support provided. People and their families were not involved in reviews of care. Staff were able to tell us about how people liked to be supported and about the actions they took to reduce risks to people. Engagement with people and their families about the service was limited and they were not always clear about the leadership. A resident and relative meeting had last been held in November 2016.

We have made a recommendation about good practice guidance on the subject of designing, delivering and reviewing peoples care and support needs and choices.

People had risk assessments carried out for skin damage and falls. Actions to minimise harm included specialist pressure equipment and the use of technology to monitor people's movements. People had been involved in decisions about how risks they lived with were managed ensuring they had freedom and choice in their lives. People were protected from risks associated with infection control as staff had completed infection control training and the home was clean.

People were supported by enough staff to keep them safe and meet their assessed care needs. Staff had been recruited safely ensuring they were suitable to work with vulnerable adults. They had been trained to recognise signs of abuse and understood actions needed if they suspected abuse. Staff completed an induction and on-going training and support that enabled them to carry out their roles effectively.

People had a well-balanced diet and were able to choose from a selection of options each mealtime. Specialist equipment was available to support people to eat and drink independently. Support with meals was provided at the persons pace and respected their dignity.

People had their medicines ordered, stored, administered and recorded safely and had access to healthcare when needed. The service worked alongside other organisations such as the community mental health team enabling better outcomes for people.

The principles of the Mental Capacity Act were being followed which meant that people's rights were being upheld. Staff had completed equality and diversity training and we observed staff respecting people's individuality and life style choices. People had been involved in end of life planning which reflected cultural and religious beliefs.

People and their families described the home as happy and told us the staff always would try and help them. We observed positive, warm, friendly fun relationships between people and the staff. Staff gave time to provide emotional support to people and demonstrated an understanding of people's individual communication skills. Interactions were respectful and included people in decisions about their day to day lives. People had their dignity and privacy respected. Signage around the home and the general layout enabled people with a cognitive impairment to orientate themselves both in the home and garden independently.

People had opportunities to engage in a range of activities in the home. Family and friends were able to visit at any time and new friendships were encouraged. Links had been made with a local school and people had gone to watch a nativity play. One person was being supported to access the community with a volunteer. When people preferred to stay in their room this was respected.
A complaints process was in place that people and their families were aware and when complaints had been received they had been investigated with the outcomes fed back to the complainant.

Staff described the culture as open and felt able to share ideas and views and contribute to the development of the service. Staff meetings were held regularly and included discussions on practice providing learning opportunities. Staff felt confident in their roles and felt that communication was effective in keeping them up to date with any changes. Throughout the inspection management and staff responded positively to areas that had been identified as requiring improvement.

We found a number of breaches 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?

Requires Improvement

The service was not always safe.

Risk assessments were completed but actions to minimise risk were not always effectively reviewed and monitored.

Staff had been trained to recognise signs of abuse and knew the actions they needed to take if abuse was suspected.

People were supported by enough staff who had been recruited safely.

Medicines were ordered, stored, administered and recorded safely.

People were protected from risks of preventable infections as staff understood their responsibilities in infection prevention and control.

When things went wrong lessons were learnt which led to improvements.

Is the service effective?

Good

The service was effective.

People had their needs and choices assessed prior to moving to the service.

Staff received an induction, on-going training and support that enabled them to carry out their roles effectively.

People received a balanced diet and are provided with choices at each mealtime.

People were supported with their healthcare needs. Working arrangements with social and health care professionals enabled effective outcomes for people.

Signage and building layout supported people's cognitive and physical needs and promoted independence.

People were supported within the principles of the Mental Capacity Act ensuring their rights were upheld.

Is the service caring?

Good

The service was caring.

People were supported by staff who respected their privacy and dignity.

People were involved in decisions about their day to day lives.

Staff were knowledgeable about people and had positive, relaxed, caring relationships with them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care and support plans were not always accurate or reflective of the care being provided.

A range of activities were available whilst respecting peoples interests, hobbies and right to private time.

A complaints process was in place that people are aware of and felt comfortable about using.

People had their last wishes respected.

Is the service well-led?

Requires Improvement

The service was not always well led.

Monitoring processes were in place but not always effective in capturing areas that required improvements.

The home did not have a registered manager in post which had left families unclear about the current leadership.

Staff spoke positively about the service and felt able to share their views and ideas.

An annual survey gathered feedback from people to support quality improvements.

Links with professionals and training organisations enabled access to best practice guidance.

Reside at Stour Road

Detailed findings

Background to this inspection

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

The inspection took place on the 11 December 2017 and was unannounced. It continued on the 12 and 28 December 2017 and was announced. The inspection was carried out by one inspector.

Before the inspection we looked at notifications we had received about the service. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. We also spoke with local commissioners to gather their experiences of the service.

The provider was not asked to complete a Provider Information Return prior to our inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

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.

During our inspection we spoke with four people who used the service and three relatives. We spoke with the managing director, deputy manager, health and safety manager, administrator, five care workers, the chef and housekeeper. We also spoke with a visiting health care assistant from a local district nursing team to gather feedback on their experience of the service. We reviewed six peoples care files and discussed with them and care workers their accuracy. We checked three staff files, care records and medication records, management audits, staff and resident meeting records and the complaints log. We walked around the building observing the safety and suitability of the environment and observing staff practice.

Following the inspection the provider sent us additional information on management audits which we considered alongside evidence gathered during the inspection.

Requires Improvement

Is the service safe?

Our findings

When we carried out our last inspection in January 2017 we found risks were not always effectively managed. Actions were put in place during that inspection to ensure better management of risk. At this inspection we found improvements had not been sustained.

People had their risks assessed and then reviewed monthly. Two people had been assessed as high risk of malnutrition. They had both been weighed regularly and had consistently lost weight each month over a 12 month period. Actions to minimise the risk included care staff completing a food and fluid diary each day and offering snacks between meals. We checked the diaries from 28 November 2017 to 10 December 2017 and snacks had not been recorded as offered. Both people needed soft food. We spoke with a care worker who had helped one of the people with their mid-morning coffee. They told us "No I didn't give a snack as only biscuits and no soft alternative". Their risk assessments stated they needed a fortified diet. We spoke with the chef who told us "Nobody is on a fortified diet at the moment". One person had no record their weight loss had been discussed with a GP or dietician. We discussed our findings with the deputy manager. On the third day of our inspection high calorie snacks were being offered between meals as well as fortified drinks. They confirmed that food was being fortified with additional calories.

This is a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with care workers who were aware of the risks to people and were able to tell us how they had to encourage food and fluids and what their favourite foods were. They told us soft snack options included cheesecake topping, yogurts and ice-cream. Care staff told us one person was able to tell them whether they wanted to eat or have a drink. We spoke with the person and this was the case. One person had an additional risk of choking and had a safe swallowing plan which included how the person needed to be positioned when they ate and liquids needed to be thickened. We observed the plan being followed correctly.

Some people had been assessed as high risk of skin damage. At this inspection we found actions from risk assessments included providing specialist mattresses and seat pads. We checked and these actions were in place. Mattress settings had been checked daily to ensure they were set correctly for the person's weight in order to ensure maximum benefit. One person had very fragile skin. We spoke with a health care assistant from a visiting surgery who explained "(Name) has fragile skin and scratches. They have four hourly turns. I've checked their sacrum and it's OK. I'm quite pleased with that". Where people required regular support to change position, charts had been completed by care staff that included the time and position the person was helped into. One person had been admitted to the home with skin pressure damage. They explained how a change of equipment used to help them transfer and the use of a sliding sheet had made a really big difference to their comfort.

Some people were assessed as high risk of falls. A relative told us "(Name) had a couple of falls through the night and they now have an alarm mat in place which has really helped". We saw that another person had a

risk of falling from bed. Their bed had been set at a very low height and had a crash mat next to it to soften a fall and reduce the risk of harm. Falls were analysed monthly to establish if there were any trends such as the time of day. Any accidents or incidents were recorded and were reviewed by the health and safety manager. Actions taken had included changes to a person's moving and transferring plan. We observed staff helping people with moving and transferring. They used equipment correctly and explained step by step to the person each action they were taking.

People had been involved in decisions about how risks they lived with were managed. One person's lifestyle choices were not compatible with a prescribed medicine. The GP had provided advice which staff had shared with the person enabling them to make an informed decision about the risk. This meant that people's freedoms and choices were respected.

People had personal evacuation plans which meant staff had an overview of what support each person would require if they needed to leave the building in an emergency. Records confirmed that equipment such as boilers, lifts and hoists were regularly serviced and maintained.

People were supported by enough staff to provide safe care although people, families and staff told us that high last minute sickness absence frequently happened leading to agency care workers being required. One person told us "There's enough staff when they are all here. If somebody is missing through health they call on agency". Another told us "If I use the bell at night they come quickly. Even if you don't ring the bell they pop in and make sure you're ok". A relative told us "Seems to be plenty of staff. I came one day and a temporary staff member was on which kept enough really". Staff had been recruited safely. Relevant checks were undertaken before people started work. For example references were obtained and checks were made with the Disclosure and Baring Service to ensure that staff were safe to work with vulnerable adults.

People and their families described the care as safe. One person said "I feel safe; there's no arguments or anything like that". A relative told us "I feel (relative) is safe living here. Before they was falling. They answer the alarm quickly which is reassuring". Another said "My (relative) is safe; they understand her dementia". Staff understood how to recognise abuse and the actions needed if abuse was suspected. One care worker told us "If I needed to I would contact the safeguarding team at the council".

People had their medicines ordered, stored, administered and recorded safely. Medicines were administered by staff who had completed training and had their competencies checked. A care worker told us "I went on a course and was told we must have PRN (medicines prescribed as for when required) protocols so I came back and introduced them". They contained information about the medicine and details about administration. Not all night staff had completed medicine training and were in the process of completing the course. On nights when no medicine trained night staff were working the process was to contact the senior staff member on call to come and administer the medicine. When people required topical creams a body map had been completed identifying where creams needed to be applied and how often. We saw these were being completed in line with the prescriptions. We spoke with staff who understood the actions they needed to take if an error was identified.

People were protected from risks associated with the prevention and control of infection. Staff had completed infection control training and used personal protective equipment such as gloves and aprons appropriately. The home was clean and odour free. A relative told us "The home is always clean". We spoke with a housekeeper who told us there were enough hours allocated to carry out their role effectively.

Throughout our inspection the service responded positively to areas raised with them that required improvement. At our last inspection we found that air pressure relieving mattresses were not being used

correctly. At this inspection systems were in place to ensure correct use is monitored daily. Accidents and incidents had been audited by the health and safety manager and led to actions taken that reduced the risk of an occurrence whilst offering opportunities for learning. An example had been a person who had been agitated whilst being transferred and sustained a minor injury. Actions had included a discussion with care staff that they explain each action step by step and await acceptance before commencing. The provider understood their responsibilities to act in an open way when things went wrong in relation to a person's care and treatment. This included sharing information with families and safeguarding teams.

Good

Is the service effective?

Our findings

People had their needs and choices assessed prior to admission using nationally recognised assessment tools. The assessment was holistic and included physical, mental, spiritual and social needs. People and their families were involved in the assessment which included details on how people choose to live their daily lives. Information gathered during the assessment had been used to create a care and support plan. Staff were able to tell us about people's assessed care needs and understood the actions needed to support people. Assessments were reviewed monthly. Changes to peoples assessed needs were discussed as part of the daily handover.

Information collected included how people were best able to communicate their choices. A care worker told us "If needed we can show signs or pictures like for example to help choose food". Health information had been sourced from external professional bodies to support staff understanding and ensure better outcomes for people. An example was information about epilepsy kept in a person's bedroom and in their care and support plan. The staff noticeboard included professional literature providing information on strokes, diabetes, sepsis, signs of malnutrition and bereavement support.

People were protected from discrimination on the grounds of their gender, race, sexuality, disability or age. Staff had completed training in diversity and equality and we observed staff respecting people's individuality and life style choices. Information collected included how people were best able to communicate their choices.

People were supported by staff that had completed an induction and on-going training which enabled them to carry out their roles effectively. The induction included for some staff completing the Care Certificate. The Care Certificate is a national induction for people working in health and social care who did not already have relevant training. Care staff were completing level 2 and level 3 diplomas in health and social care. The owner told us "For the diplomas it's always the dementia pathway". A care worker explained "My dementia training has helped me understand the different types of dementia and how people have different needs". Staff told us they felt supported. One care worker told us "Since (registered manager) left in September I haven't had sit down 1-1 supervision but I definitely feel supported; it's like one big family. I've got all my training covered including moving and handling".

Information about people's eating and drinking requirements had not always been updated in the kitchen. An example was catering staff not being aware of people who needed a fortified diet. Information collected included people's likes and dislikes and any special dietary requirements. Information was displayed on a noticeboard in the kitchen. The chef said "It helps if it's an agency cook. It even includes breakfast preferences". People were offered a choice at each mealtime and described the food as good.

One person told us "The food is really good; they've been feeding me up". Another told us "The food is first class, smashing. We normally get a choice of two things but if you said can I have a sandwich they would do that. The chef when he gives us lamb slices and potatoes he will wrap a little cocktail sausage in bacon. These little extras make you realise he is well trained". People were involved in menu planning. The chef

explained "I've attended resident meetings. They told me there not keen on pasta so that's been taken off the menu". We observed staff offering a variety of drinks throughout the day. Some people used specialist beakers or plate guards to enable them to eat and drink independently. When people required assistance with eating and drinking staff provided help at the persons pace maintaining their dignity.

The service worked with other organisations when planning and carrying out care. An example was when a person was agitated and the community mental health team came in daily to carry out an assessment. The deputy manager told us "They were brilliant. They sorted out (name) medicines by changing the time it was given and we also were able to identify that workmen creating a noise in the home were a trigger. It meant that the last time we did jobs was when (name) was away at her family's".

People had access to healthcare when needed and this included GP's, district nurses, specialist health teams, chiropodists, and opticians. When people needed to access other health services information was provided to ensure their safety and health and welfare. This included emergency contact details, medicines and basic details of how the person liked to be supported and how they communicated. One person told us "If I'm poorly the staff organise a doctor quickly. Last time I had a hospital appointment one of the carers came with me".

The signage and building layout provided opportunities for people living with a dementia to orientate themselves around the property and gardens independently. Bedroom doors had visual prompts such as photographs of the person, name plates as well as a number. Toilet and bathrooms had clear written and pictorial signage. Space was available for people to have both private time or socialise with others in a communal area.

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.

We found that the service was working within the principles of the act. Mental capacity assessments had been completed for people and DoLs applications had been submitted to the local authority. One person had a DOLs authorised with conditions. The deputy manager explained how the condition had been met but that risks had been had required reviewing with family and the local authority to ensure the persons safety. We saw that best interest decisions had been taken for people and had included input from staff, families and social workers. People living at the service were not all able to express their consent verbally. Staff told us of communication tools used to help people express how they felt and the different non-verbal ways people expressed themselves. Files contained copies of power of attorney legal arrangements for people and staff understood the scope of decisions they could make on a persons' behalf. Records included advocacy support one person received in relation to decisions about finance, health and welfare.

Good

Is the service caring?

Our findings

People and their families described the staff as caring. One person told us "The staff are good; they will always try and help you out". A relative told us "It's a really happy home with a lovely atmosphere". Another explained how staff had gone the extra mile when there had been a special family event. They told us "They made sure (relative) had a bath, organised the hairdresser to visit and got her all glammed up". They went on to say "Staff have taken time to get to know (relative)".

Throughout our inspection we observed positive, warm, relaxed relationship between people, their families and the staff team. We saw staff and people enjoying cheeky friendly banter, laughing and having fun. A care worker told us "We have fun with the residents and enjoy the activities together". A game of musical bingo had been organised and one person wanted to play but had poor sight. We observed a care worker put their arm on their shoulder and say "Don't worry I can help you; we can play it together".

We observed one person becoming a little agitated as they were anxious about a relative visiting. A care worker sat with them for some time offering reassurance, and providing emotional support. They repeated the reassurance several times, remained calm, patient and demonstrated good listening skills. The person eventually responded positively to the support and it reduced their anxiety.

Staff had a good understanding of people's interests, likes and dislikes. This meant that staff could have conversations with people about things that were important and of interest to them. We observed staff asking a person if they were they would like to sit and suggesting next to another person who they got on well with. We saw staff respecting and supporting peoples individual lifestyle choices. People's personal space reflected the person's individuality and included personal possessions including photographs, ornaments, books and music.

Interactions between staff and people were respectful and involved the person in decisions. Throughout the inspection we observed staff explaining their actions to people, giving people time and listening to what they had to say. Decisions people made about their care and support were respected. One person requested their bedroom door be locked during the day and we saw care staff carrying this out and returning the key to the person. One person told us "I'm involved in how I'm cared for and they would do something differently if I asked; they are good here".

Some people needed additional support with communicating their decisions. We observed staff using appropriate non-verbal communication to demonstrate listening and to check people understood them. For example talking with people at eye level and using hand gestures and facial expressions. A care worker described how they pointed to things like a cup of tea or the bath to aid a person's understanding of what was being suggested. Another told us the actions a person did to let them know they were hungry. People who needed an independent representative to speak on their behalf had access to an advocacy service.

Care workers were able to describe the actions they took to ensure a person's dignity was respected. Examples given were covering a person with a towel when providing personal care and knocking on

bedroom doors before entering a room. Information about people was stored securely to ensure their right to confidentiality.

Requires Improvement

Is the service responsive?

Our findings

People did not have care and support plans that always reflected person centred care needs and choices. Assessments of peoples care needs had been completed but the actions needed to meet peoples identified needs were not always detailed. We looked at a care plan for one person who had wounds. The care plan gave no detail of the wounds, no detail of the district nurse support and no detail of the pressure relieving equipment in place. We spoke with the person and they described how staff make them comfortable in bed to relieve pressure. This was not recorded in their care and support plan. A care worker told us one file stated the persons spouse had died but they hadn't. They explained "I've told them (management) but it hasn't changed". They went on to say "The care files don't give you enough information. It can be a problem with paramedics and new staff". However staff were able to tell us how people liked to be supported and spend their day. One care worker told us "We have handovers and they really work. Information gets passed over and it's also recorded in care docs (electronic care plan system). A visiting health care professional told us "Staff knew about the patient I saw and knew about their wounds". This meant that although staff had a knowledge of people they were at risk of not receiving consistent, person led care, support and treatment as care and support plans did not provide the necessary detail to guide staff.

People and their families had been involved in an initial assessment of care needs. A relative told us "We've had no discussion with staff about (relatives) care, no review of how they've settled in". The deputy manager told us people and their families currently were not involved in care plan reviews.

We recommend that the service consider NICE guidance or similar nationally recognised guidance when designing, delivering and reviewing peoples care and support needs and choices.

Families had mixed views on how well they were kept informed. One family described how staff always answered any concerns they had and kept them up to date with things whilst another described two health appointments their relative had attended that they had not been made aware of until after they had occurred. The deputy manager told us they would remind staff that the process should be that families are telephoned and advised of appointments or concerns.

We observed people engaged in activities including music singalong, choosing a Christmas movie to watch together, a quiz, art and musical bingo. One person told us "They keep me busy it's not a bad thing". Another person was painting a picture which coloured to touch enabling people with poor dexterity to participate. It led them to reminisce about art they had enjoyed in their younger days. A relative told us "One of the carers took (relative) to see (singer) and they looked after her. There off to the nativity play this afternoon". The deputy manager told us a childminder visited with her children and people loved that. One person told us they needed to accompanied when they went out and a volunteer had been arranged for once a week.

The chef told us how he had been involved in helping with activities. He said "I've made pizza dough, rolled it out and they've put the toppings on or cut out scones for them to bake. We always make a birthday cake

when it's somebody's birthday".

A care worker told us about two peoples friendship. "They like to sit up and watch TV together; they love to sit and watch the sport together". Foxes visited the garden each evening and people were animated by them and told us about the nightly get togethers in the conservatory to watch the fox family feed.

One person spent their time in bed. A care worker told us "They have the radio on through the day. We go and sit in their room and chat with them. (Name) kept herself to herself when she was able to walk about; always preferred being in her room".

A complaints procedure was in place and displayed around the home. A relative told us "I have been given information about how to make a complaint". One person told us "The staff do listen and for the main they will put it right". Another told us "If I was unhappy I would speak to one of the staff and they would try and sort it out". We looked at the complaints log and formal complaints had been investigated and the outcome shared with the complainant. The complaints process included details of how to appeal to the independent local government ombudsman.

People and their families had been involved in decisions about their end of live wishes which reflected cultural and religious beliefs. We read thank you cards complimenting staff on their support of people and their families during a person's end of life care.

Requires Improvement

Is the service well-led?

Our findings

The service had been without a registered manager since October 2017. Oversight of the service was being provided by the provider and the deputy manager. The provider told us that a new manager had been appointed and was due to start in January 2018.

People had not always been protected from avoidable harm as risks relating to the health, safety and welfare of people had not always been monitored. Auditing systems had not included monitoring the effectiveness of actions taken to reduce risk. This meant that actions had not been taken when food and fluid diaries showed poor calorie intake or a person consistently lost weight. Care plan audits had been carried out by head office. After our inspection we spoke with the administrator who carried out care plan audits. They told us "The purpose of my audits is to ensure the care plan doesn't contradict itself. Not necessarily to see if the plan matches the care". They went on to say that they would meet with the home to re look at how audits are carried out to ensure they capture risk and monitor the effectiveness of actions.

A health and safety audit had been completed in June 2017. One action had a priority rating which was that the names of first aid trained staff needed to be displayed. At the time of inspection this remained outstanding.

Records for people were not always accurate or complete which meant people were at risk of receiving inconsistent care and treatment that did not reflect their needs or wishes.

This is a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engagement with relatives about the service was limited. The last relative meeting had taken place in November 2016. One relative told us "I visit several times a week and I've no idea who leads the home". This meant relatives were not kept up to date with changing events at the service.

Staff described the culture as open and inclusive which enabled them to share views and ideas. One care worker told us "We have regular meetings. We asked for a second hoist and that has happened". Staff had raised with the deputy that when there were two team leaders working on a shift they sometimes got conflicting instructions and were unsure who was leading the shift. The deputy manager told us "It's now marked on the rota; it's very clear who the shift leader is". A care worker told us "Work is planned at handover; you know what your responsibilities are".

The deputy manager told us they felt very supported by the provider. They said "Head office have been brilliant, admin, health and safety and the provider will always come if I needed them too; I feel very supported".

Staff meetings took place and included opportunities for reflecting on practice. We read minutes were staff had discussed catheter care, infection control and laundry systems. Staff told us they understood their roles

and responsibilities and felt that they were kept informed of things. An annual quality assurance survey had been completed and the provider told us the outcomes and actions would be emailed to all the staff team.

Links with other agencies included Skills for Care and the Alzheimer's Association which had influenced staff training.

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 Risks identified for people had not been consistently managed or actions taken in order to minimise the risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not effective in monitoring and mitigating avoidable risks to people. People's records of their care and treatment were not always accurate or complete.