ARMSCARE Limited

Summerville 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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Summerville House is registered to provide accommodation and personal care for up to 26 people, some of whom live with dementia. The home, which is situated in a West Norfolk seaside resort, has two floors, with communal dining, lounge and bathing and toilet facilities. There is an enclosed garden to the rear of the home. Short and long term stays are offered. At the time of our visit there were 25 people using the service.

This comprehensive inspection took place on 9 February 2016 and was unannounced.

A registered manager was in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were kept safe most of the time and staff were knowledgeable about reporting any incidents of harm. However, there was inadequate action taken to report a significant safeguarding concern to the local authority. We received mixed views about staffing numbers although when we visited people were looked after by enough staff to support them with their individual needs. Satisfactory pre-employment checks were completed on staff before they were allowed to look after people living in the home. People were supported to take their medicines as prescribed and medicines were safely managed.

People were supported to eat and drink sufficient amounts of food and drink and there were choices of food from what was on the main menu. They were also supported to access health care services and their individual health needs were met.

The CQC is required by law to monitor the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. Assessments were in place to determine if people had the capacity to make decisions in relation to their care. When people were assessed to lack capacity, their care was provided in their best interests. However, DoLS applications had not been made to responsible authorities when some of the people had restrictions imposed on them. Therefore the provider was not acting in accordance with the requirements of the MCA.

People were supported by kind, respectful and attentive staff. People, or their relatives, were not given opportunities to be involved in the review of their individual care plans.

People were supported with a range of hobbies and interests that took part in and out of the home. Care was provided based on people's individual needs. There was a process in place so that people's concerns and complaints were listened and responded to.

Although the last Care Quality Commission rating of the home was available on the provider's website, this was not on display in the home. This omission had reduced the provider's ability to demonstrate that they

operated a transparent culture as part of their duty of candour.

People were looked after by some but not all staff who were trained and supported to do their job. The registered manager was supported by a team of managerial, care and ancillary staff. Staff were supported and managed to look after people but the systems used to do so, were not robust enough to monitor the progress of the training of staff.

Staff, people and their relatives were able to make suggestions and actions were taken as a result.

Quality monitoring procedures were in place but these had not always been effective to detect the omissions that we had found during our inspection. In addition, there was a lack of reviewing and analysing information in relation to incidents that had taken place. Therefore, there were missed opportunities to take action, if needed, to improve the safety and quality of people living at Summerville House.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to lack of submission of DoLS applications to the appropriate authorities, staff training and quality assurance. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People did not always have their individual needs met due to inconsistent numbers of available staff.

Recruitment procedures ensured that people were looked after by staff who were deemed suitable to do the job that they had applied and been accepted for.

People's medicines were handled and managed by staff who were trained to do so.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff had attended training to safely and effectively look after people.

The provider was not consistently following the Mental Capacity Act 2005 which meant that people's rights were not always being protected.

People's physical and nutritional health was maintained.

Is the service caring?

Good

The service was caring.

People were looked after by kind and caring staff.

People's right to privacy and dignity was respected

Staff respected and valued people's decisions about how they wanted to be looked after.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People or their relatives were not actively involved in the care

plan review process.

People were provided with a range of activities that took place in an out of the home.

There was a complaints procedure and the provider had taken action to the satisfaction of the complainant.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There were ineffective systems in place to monitor the progress of staff training to keep people from the risk of unsafe care.

There were ineffective auditing procedures in place to analyse information so that action may be taken to reduce the number of incidents occurring.

The provider reduced their ability to demonstrate their Duty of Candour due to the lack of display of their ratings in the home.

Summerville 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 was carried out on 9 February 2016 and was unannounced. The inspection was carried out by one inspector.

Before the inspection we looked at all of the information that we had about the service. This included information from notifications received by us. A notification is information about important events which the provider is required to send to us by law. Also before the inspection we had contact with members of staff employed by the local authority.

During the inspection we spoke with five people, one visitor and two people's relatives. We also spoke with the registered manager; the deputy manager; the Nominated Individual [a named person representing the registered provider]; five members of care staff; a hairdresser; a member of the catering staff; an activities co-ordinator and a visiting health care professional. We observed care to help us with our understanding of how people were looked after.

We looked at four people's care records, medicines administration records and records in relation to the management of staff and management of the service.

Requires Improvement

Is the service safe?

Our findings

We received mixed views about the staffing numbers. One person told us that there were not enough staff and said, "You have to sit around, waiting a lot (of time) because they are short staffed. So, you do find yourself sitting around a lot." A member of care staff said, "Sometimes the lunch time and sometimes the morning we have been known to run on three staff. (It's) been due to sickness, days off, holidays. We just work through it." They also told us that sometimes people's care was not always carried out as planned. This included assisting people to change their position when in bed. They said, "It (repositioning) is supposed to get done three-hourly, but it doesn't always get to be done. Shortage of staff. (There is) no time." The registered manager told us that when the activities co-ordinator was not working in the home, members of care staff were responsible for assisting people to take part in recreational activities. However, this depended on the staffing situation. Staff said, "(We) are not always able to do this every day. (It is) depending on staffing (numbers)."

The registered manager told us that measures were taken to cover staff absences with the use of staff who were employed to work at the provider's 'sister' homes. However, they said that this was not always possible to use such staff due to their own work-related commitments. This meant that sometimes there was an insufficient number of staff working. A member of catering staff said, "If someone goes off sick at the last minute, it can put you in a bit of a predicament. They [members of the management team] do their best to get someone in to provide the cover."

Other people we spoke with, which included visitors, told us that there were usually enough staff to look after people. A visiting health care professional said, "Staff are very helpful and there is enough staff to help with getting people (to me) to be treated." A relative said, "(There) are enough staff when I come in." We saw that people were being looked after in an unhurried way as there were enough members of staff on duty when we visited. People were given time to take their medicines and were assisted with their food and drink by individual members of staff, if this was needed. We also found that people were having their care, which included assistance with repositioning, as planned. A member of care staff said, "Today is fine. It (staffing) depends on the health of the residents [people who live at the home]." The registered manager told us that there was no staffing tool used to determine the number of staff required to meet people's needs. However, there were fixed numbers of staff rostered to work, which included the registered manager. We saw the registered manager working along-side members of staff during the busy lunch-time period.

People said that they felt safe because staff treated them well. One person added that they felt safer since they had a lock provided on their door. They said that this was to discourage other people from entering their room. A relative said that their family member was "definitely" safe because of how the staff looked after and treated them.

Two out of three members of care staff and the deputy manager were able to describe the types of harm that people may experience. They were also able to describe the reporting actions that they would take if they believed or witnessed any such event. This included reporting to the management team or the local safeguarding authority. Staff members were able to demonstrate their knowledge in the signs of someone

being harmed. The deputy manager said, (that a person could be in a), "Low mood. Stressed Bruises may appear." One member of care staff said, "(The person) could be quiet. Bruising."

Two members of care staff told us that they had not attended training in safeguarding people at risk of harm. One member of care staff told us that they had been in post since November 2015 but had not attended such training. We were not confident in their knowledge of safeguarding as they were unable to name types of harm that people may experience which would need reporting. They also were unaware of who they would report to of any safeguarding concerns they may have. Another member of care staff had been working in the home for eight months but also said that they had not received training in safeguarding people at risk. Information in relation to staff training in safeguarding people at risk showed that not all staff had up-to-date training; only 65% of all staff had attended this training.

A relative told us that their family member had experienced an incident which posed a significant risk to their safety. The person's records confirmed this was the case. However, the registered manager told us that correct safeguarding reporting procedures had not been followed. They explained that this action had not been considered to be the next - and correct - step to take. This would have included raising the incident with the local authority and notifying the Care Quality Commission (CQC). Therefore, we were not fully confident that people were kept safe from the risk of harm due to lack of staff training and knowledge in this area.

Risk assessments were in place for people, in areas such as developing pressure ulcers and moving and handling. Measures were in place to manage the risks, which included the provision of pressure-relieving and moving and handling equipment.

The deputy manager advised us that half of the people in the home required assistance with their moving and handling needs. However, only 68% of staff had been assessed to be safe with this care practice. One member of care staff told us that they had watched other members of care staff to support people with this need. They told us that they assisted people with this procedure but had not attended formal moving and handling training. Training records confirmed that only 21% of care staff had attended formal moving and handling training. Therefore, we could not be assured that people were fully protected against the risks associated with moving and handling procedures.

Members of staff had an understanding of managing the risks and what it meant to people. One member of care staff said, "It's getting people to take risks. For example, letting them walk up and down the stairs. But we would walk with them. Maybe when they have a shower (there are risks)." They told us that they would manage the risks with the level of assistance the person needed to maintain both their independence and safety.

Around the premises people, staff and visitors had guidance and instructions in what to do in the event of a fire. One member of staff, however, was unable to demonstrate that they were aware of the actions they would take in the event of a fire. They also told us that they had not received training in fire safety since starting their employment in November 2015. Their records confirmed this was the case. This placed people at risk in the event of a fire.

Recruitment procedures were in place to vet staff before they were deemed suitable to look after people living at Summerville House. One member of care staff described how they were recruited to work at the home. They said, "I had a DBS (Disclosure and Barring Service) (check). After I filled an application form in, I had an interview. There were two written references." Another member of care staff told us that they, too, had all the required checks completed before they started their employment. Staff recruitment files

contained the required checks before the prospective member of staff was allowed to commence their employment.

People told us that they were satisfied with how they were assisted to take their prescribed medicines. One person said, "People [staff] are trained to do it." They also said that they were given their medicines as prescribed. A relative said, "[Family member] has settled down a lot. I think it is because of his medicine." We saw that people were given time to take their medicines and were checked that they had safely swallowed these.

People's records for medicines showed that people were helped to take their medicines as prescribed. The use of covert (hidden or disguised in food or drink) medicines was approved by people authorised to do so. Medicines were stored securely and audits demonstrated that the stock levels of medicines were kept under review and accounted for.

Members of staff, who were responsible for the management of people's prescribed medicines, were trained to do so. The deputy manager advised us that the registered manager had observed their practical skills to check that they were competent in their practice. A competency framework assessment tool was available. However, completed staff medicine competency assessments were not available to support this action.

Requires Improvement

Is the service effective?

Our findings

We found that some people had their liberty restricted. This was through the use of bed rails, a recliner chair (that the person was not able to independently operate due to their condition) and an alarmed door to the entrance of the home. In addition, the registered manager advised us that one of the people was looked after in bed all of the time due to a physical condition. They also told us that some of the people were unable to leave the home unless they were escorted. They said, "(There is a) number of people not able to leave on their own. It's for safety reasons." Information provided by the registered managed showed that applications had not been made to the local supervisory body to approve that these restrictions were lawful.

This was a breach of Regulation 11(3) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

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. We checked whether the service was working within the principles of the MCA. At the time of our inspection not all of the people who lived at the home had mental capacity to make decisions about their support.

Mental capacity assessments were carried out and people were provided with care in their 'best interest'. This included, for example, assistance with eating, drinking and personal care. The practice of covert administration of people's medicines was found to be justified and based on 'best interest' decision making procedures.

Staff training records showed that nearly all of the staff had attended training in the application of the MCA. However, we found that all of the staff whom we spoke with were unable to demonstrate the knowledge they had gained from their training. This included, for example, understanding the principle of people having capacity unless assessed not to have capacity to make informed decisions. Nevertheless, members of staff were able to show how they gained people's consent in relation to their day-to-day care. This included using effective strategies to enable a person to give their consent to be assisted with essential personal care. One member of care staff explained the strategies that they used. They said, "I just explain what I am going to do. When I am not able to (because the person had not given their consent) I ask another member of staff (to help)." They told us that they only supported people when the person had given their permission. A visiting health care professional told us that they informed people of the reason for their treatment in way that they were able to understand. This information had enabled people to consider and give their consent to be treated.

Staff told us that they had attended induction training when they first started their employment. One member of care staff said, "I did two days 'shadowing' with a senior member of staff. I didn't (though) do my

moving and handling training." Another member of care staff said that they had attended induction training which was watching other staff members at work. However, they told us that since starting their employment, they had not attended training in safeguarding people at risk, fire safety or moving and handling training. Their records confirmed this was the case. This meant that people were placed at risk to their health and safety by staff who had not been adequately trained to do their job that they were employed to do.

Staff training records demonstrated that staff had attended training in dementia care, management of people's medicines and the application of the MCA. However, the training records showed that some of the staff training was not up-to-date, which included moving and handling and safeguarding people at risk.

This was a breach of Regulation 18 (2) (a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

A member of care staff said that they had attended training in looking after people living with dementia. They gave examples of how they applied their training into their practice. This included, for example validating a person's sense of reality (as opposed to correcting the person's understanding) and talking with them about their long-term memories. A member of care staff told us that they were aware of the training that they needed to do. They said, "I have an on-line certificate in care to do." Another member of care staff told us that they had future training arranged for control of substances hazard to health.

Staff said that they felt supported to do their job and received one-to-one supervision. They told us that during this time they were asked about their health and welfare, work-related issues and training needs. The deputy manager told us that they were responsible for checking that members of staff were progressing with their training. However, both the deputy manager and registered manager advised us that the one-to-one supervision of staff did not check on the progress of staff in keeping up-to-date with their training. Therefore there was a missed opportunity in ensuring that people were safely looked after by staff who were trained to do so.

People said that they were given a choice of what they liked to eat and told us that the food was "alright". They also said that they had enough to eat and drink. Visitors, which included relatives, said that they believed people had enough to eat and drink.

We saw that staff assisted people with their eating and drinking where necessary and encouraged and prompted them to eat their food. Alternative choices from the main two lunch time menu options were available, which included cold meat and soft boiled eggs. Soft diets were provided for people who had difficulty in chewing and swallowing their food. To minimise the risk of people from the risk of choking, thickened drinks were provided. Prescribed nutritional supplements were made available for people who were assessed to be at risk of inadequate nutritional intake of and milk shakes were also offered to people assessed to be at such risk. The amounts of what people ate and drank were reviewed by staff members with a member of the catering staff. Records were maintained for the amounts of what people ate and drank, if the risk indicated that this action was required. The frequency of when people were to be weighed was dependent on the level of their nutritional risk. Weight records showed that people were getting enough to eat and drink to maintain their nutritional health.

One person told us that members of staff had assisted them to access health care services provided by a GP and district nursing practice. They said, "The GPs come every Monday. So the provider is not negligent in that way." A relative said, "[Family member] had a chest infection and the GP came and prescribed antibiotics. [Family member] is a lot better now." A member of the catering department advised us that

people had been assessed by health care professionals who worked in community mental health teams and nutritional services. The registered manager advised us that one person had acquired a low graded (not serious) pressure ulcer and this was being treated by the district nurse. On the day of our visit some of the people were being treated by a visiting health care professional. They told us that they visited the home regularly every six weeks to treat people or sooner if required.

Good

Is the service caring?

Our findings

People said that they liked the staff and got on well with them. One person said, "I've never felt more at ease here than when I have been to other places. I've never felt lonely here." A relative said, "This is about the best place. [Family member] is settled here. [Family member] gets on well with [registered manager]. Everyone. [Family member] likes the staff and gets on well with them." A visiting health care professional said, "I find this (is) a very nice home. Very friendly."

We saw staff engaged with people in a warm and attentive way. This included checking if people were comfortable, if they needed any help as well as talking to them in a sociable way. Staff were patient with people when assisting with their food and when they were walking with them.

Staff members told us that they liked their job of looking after people. A member of the catering staff told us that they enjoyed making sure that people's nutritional needs were met and knowing what people liked to eat. A member of care staff also told us about the satisfaction they gained from caring for people and making them comfortable.

The visiting health care professional told us that they treated people in the privacy of their bedrooms or in the staff/treatment room. We saw that people received personal care and health care treatment behind closed doors.

Staff respected people's privacy and dignity when they provided them with personal care or when entering their room. One member of care staff said, "Getting someone to clean their own teeth or brush their own hair. It makes a big difference (to the person's well-being)." Another member of care staff said, "I knock on the [person's] door before going in." We saw members of care staff knock on people's doors before entering. However, they did not wait to allow the person to give their permission; where that was possible.

People's independence was respected with their eating and drinking. Staff members encouraged people to eat and drink and helped people only when they were not able to be independent with this task. People were also encouraged to be independent with walking. One person said that they were learning to regain their independence with their walking.

The home offered people with privacy as toilet and bathing facilities were provided with overriding locks on doors. Single and double occupancy rooms were available; the registered manager advised us that the sharing of rooms was based on consent from people's representatives. Bedroom doors were provided with screened windows to allow people privacy when they were in their room.

Appropriate cloth tabards were worn by some of the people to protect their clothing from spillage of food and drink. A relative told us that when they visited they found their family member wore clean clothing. However, we saw that this standard of practice was not consistent; we saw four people were wearing stained tops, one of which a member of staff had unsuccessfully cleaned with the use of a paper tissue. This meant people's dignity was not always maintained.

People were offered choices about how they spent their day. One person said that they had not slept well the night before and was left to "catch up" with their sleep. The deputy manager and member of care staff told us that when they had arrived on duty, on the day of our inspection, some of the people were out of bed. We were told that this was their choice to do so. The deputy manager said, "Some people like to get up early." This was confirmed by the member of care staff who said, "It was because people were ready to get up."

The registered manager told us that advocacy services were used to support people in decision making when this support was required. Advocates are people who are employed by advocacy services and who are independent and support people to make and communicate their views and wishes.

Requires Improvement

Is the service responsive?

Our findings

People and relatives told us that they had been involved in the process of assessing people's individual needs before admission to Summerville House. This was so that all parties were satisfied that the provider was able to meet people's individual needs. However, none of the people we spoke with, and who were able to tell us, had been actively involved in the review of their planned care following admission to the home. One relative told us that they did not "really" know about the presence of their family member's care plan.

People's care records were electronically held and there was a system in place to alert staff when these records, including risk assessments, needed to be reviewed. The registered manager told us that people's care records and risk assessments were to be reviewed "monthly or sooner." We found, however, some people's care plans had not been updated within this expected time. For example, one person's care records had not been reviewed since October 2015. Their care plan and risk assessments showed the person had a high level of mental and physical health needs. Another person's mental health care plan had not been reviewed since January 2014. Members of staff and incident records demonstrated that the person became frequently unsettled and presented with behaviours that had challenged others. This meant staff did not have the most up to date information to ensure effective care was provided.

People's individual needs were assessed and care was planned to meet their assessed needs. One person said that they were aware of the reason for short stay admission to Summerville House. This was to rehabilitate before returning back home. People's other care needs were assessed and plans were in place to enable staff to meet these needs. These included, for example, supporting people with their dementia needs. The assessments were based on how people's dementia affected their memory, orientation and ability to be independent and safe. Members of trained care staff demonstrated how people's dementia care needs were met. This included reminiscence therapy and communicating and engaging with the person in the way that mattered to them. A visiting health care professional, who had experience in caring for people with mental health needs, told us that staff members communicated well with people who were living with dementia.

People said that staff knew them as an individual. One person said, "I do feel so (that staff know them)." A member of care staff told us that one of the positive aspects of their job was getting to know the person and enthusiastically told us about a person's past interests and life history. They said, "I (also) enjoy involving relatives with this." People's care records showed that information about the individual person was incomplete. The registered manager told us that they had asked people's relatives but had "often" found getting this information difficult.

People's care records showed that people's "spiritual" needs were "fulfilled". The registered manager advised us that a choir from a local religious organisation attended the home every month to sing to people. However, there were no other religious services attended by people. The registered manager told us that the assessment of people's "spiritual" needs would be revisited to ensure that the care records were accurate.

One person told us that they enjoyed listening and watching the activities. They said, "Entertainment is quite

good." A relative said that their family member enjoyed taking part in the activities. They said, "It's been very good when people [entertainers] come and [family member] likes to join in. Music days (are when) [family member] likes to dance." They said, however, "I always think there should be more to keep people active than they [staff] do." The activities co-ordinator told us that they supported people to take part in a range of arts and crafts; music and exercise therapy and to take trips out. Records confirmed this was the case. The activities co-ordinator advised us that people had access to a range of puzzles, quizzes and sensory items to support people living with dementia. We saw members of staff sit and talk with people in a sociable manner.

People told us that they knew how to make a complaint. One person said, "I'd speak to [name of registered manager]." They told us that they had raised some concerns with the registered manager. Action was taken in response to the person's concerns and said that they were satisfied with the outcome. The record of complaints showed that one complaint, which had been raised by a relative, was investigated and this was to the satisfaction of the complainant.

Requires Improvement

Is the service well-led?

Our findings

The quality assurance systems were not sufficiently effective to protect people from the risks of substandard care. The NI told us that audits were carried out by an operations manager. The registered manager said that the audits covered "everything". The NI told us that no records were maintained of these audits. Therefore, we were unable to assess the effectiveness of these quality monitoring visits. In addition, we found a number of areas that required improvement, which a robust quality assurance auditing system should have identified and subsequent remedial action taken. This included identifying the lack of display of rating; the lack of DoLS applications and lack of reviews of people's care plans and their involvement with the review process.

The NI had carried out a visit during the night of 29 January 2016 and reported back to the deputy manager. This was for action to be taken to improve the uptake of staff training "as soon as possible" although no actual dates for completion were made. Staff attended supervision sessions although the progress of their training was not discussed. Both the registered and deputy managers said that this was an area that required improvement.

Incident records demonstrated that from 01 November 2015 to when we visited, there had been eight occasions that had posed a risk to the safety of staff and one occasion in respect of a visitor to the home. However, there was no system in place to analyse the information available so that any remedial action may be taken based on the results of the analysis.

This was a breach of Regulation 17 (2) (a) (b) (c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

Our last comprehensive inspection of the home was carried out on 4 and 5 March 2015 when we gave Summerville House its first ratings. During this inspection of 9 February 2016 we found that the provider had details of the ratings of the home published on their website. However, we were unable to find the ratings displayed in a visible and conspicuous way in the home. A health care professional told us that they had not seen the ratings displayed when they had visited Summerville House. The registered manager and Nominated Individual (NI) told us that a copy of the report of the inspection of March 2015 was made available in the entrance of the home. However, we found this was no longer available for people to see. In addition, the provision of a copy of a report of a rated inspection does not fulfil the requirements of the regulation. This reduced the provider's ability to demonstrate their Duty of Candour and understanding of the requirements of the regulation.

Notifications were submitted as required with one exception. This was in relation to a significant safeguarding concern; an incident that posed a serious risk to the safety of a person living with dementia. Therefore we were not confident that people were always kept safe due to lack of following correct safeguarding people at risk procedures.

The registered manager was supported by a team of managerial, care and ancillary staff. We received

positive comments about the registered manager. We heard that he was approachable and that had taken steps to improve the quality of the service, based on people's suggestions. This included, for example, improving the range of activities based on staffs' suggestions and creative ideas.

Members of staff were enabled to share their views and make suggestions to improve the quality of people's experiences of using the service. A member of the catering staff said, "We had a staff meeting yesterday. Everybody can have an input." They told us that they had made a suggestion to improve the quality of some of the people's drinking by the means of lighter, non-breakable, brightly coloured beakers. A member of care staff told us that they had suggested a display of colourful hats for people to wear and this, too, was acted on. The staff meetings also enabled the management team to remind members of staff of their roles and responsibilities. This included, for instance the roles of the keyworkers [named staff who are responsible for looking after named people who live at the home].

People and their relatives also had opportunities to share their views about the service. This was on an informal basis or during meetings. Action was taken, for example, to remind key workers to protect people's personal clothing from going missing or becoming lost.

Members of care staff were aware of the whistle blowing procedure and said that they had no reservations in reporting any concerns to the provider or external agencies, such as the local authority. In addition, they gave examples of when they would follow the whistle blowing policy. One member of care staff said, "If I have a problem (concern about a colleague) I would escalate it (through the management system) until I'm heard." The deputy manager said, "We have a whistle blowing policy and procedure and we have contact details in the office. It (whistle blowing) is if we want to report a colleague or abuse by a colleague." This showed that there was an open culture operating in the home. Members of staff told us that the registered manager was available to discuss any concerns they may have.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person was not acting in accordance with the Mental Capacity Act 2005. Regulation 11(3) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were ineffective systems to assess, monitor and improve the quality and safety of the care provided. Care records were not reviewed to ensure that staff had the right guidance to provide safe care. Regulation 17 (2) (a) (b) (c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not trained to enable them to carry out their duties that they were employed to do. Regulation 18 (2) (a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).