The Meadow

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Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Inadequate**
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**

Overall summary

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 and to pilot a new inspection process being introduced by the Care Quality Commission (CQC) which looks at the overall quality of the service.

The Meadow provides care for up to 40 older people who may also have dementia care needs. There are two separate units where people are accommodated, one on the ground floor and one on the first floor. The ground floor unit provides care and support specifically for people with dementia care needs.

The last inspection of this service took place on 22 May 2013. During that inspection we found that the service was meeting regulations related to respecting and involving people, care and welfare, nutrition, staff recruitment and support, medicines and assessing and monitoring the quality of the service.

Summary of findings

This inspection was an unannounced inspection. At the time of our inspection 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 and associated Regulations about how the service is run.

People were not kept safe at the service. Behaviour that challenged the service was not managed in a way that protected people from harm and staff were not clear about how to manage these risks. People's needs had not been fully assessed prior to their admission to the service to ensure that staff could meet their needs.

People were not always asked about their likes, dislikes and preferences and care plans were not always updated to reflect changes in people's needs. Records were not always kept up to date so there was a clear record of people's wellbeing and any support they needed.

Staff recruitment checks were not robust and therefore did not ensure that all staff employed were suitable to work with vulnerable adults. Staff with the required experience and expertise were not always on shift and staff sometimes worked extra hours which may have meant they had not had enough rest to make sure they could carry out their duties effectively.

We found that the service did not fully consider people's mental capacity and the impact of any restrictive practices to ensure that people's rights were respected.

People told us that staff were caring and treated them with respect. Our observations confirmed this.

People told us they enjoyed the activities provided at the service and told us that staff listened to their views. We found that people knew how to make a complaint and felt comfortable raising any concerns. The manager responded to any complaints promptly and addressed any issues raised.

Systems were in place to monitor the service, however, we found that these were not always effective in ensuring that the service met the required regulations.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Staff did not manage behaviour that challenged the service in a way that protected people and pre-admission processes did not adequately assess if the service could meet people's needs.

Staff recruitment checks were not fully completed and therefore did not protect people from staff who may be unsuitable to work with vulnerable people.

The service did not fully consider people's mental capacity and the impact of any restrictive practices to ensure that people's rights were respected.

Is the service effective?

Requires Improvement

The service was not effective. People had mixed views about the food provided by the service and we found that people's nutritional needs were not always monitored effectively.

New staff received an induction to the service and had meetings with their manager to support them in their role. However, the training provided did not always equip staff with the skills they needed to meet people's needs.

People were referred to appropriate healthcare professionals when health concerns were identified.

Is the service caring?

Requires Improvement

Not all aspects of the service were caring. People using the service and their relatives spoke positively about staff and the care they received. We observed warm and positive interactions between staff and the people using the service.

People's privacy and dignity was respected. However, people's personal information was not always kept confidential.

People were not always fully involved in planning their care.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive. People's needs had been assessed but care plans did not always reflect people's preferences or contain enough detail about the person as an individual.

People were given information about how to make a complaint and the manager responded promptly to resolve any issues.

A range of social and leisure activities were arranged which people told us they enjoyed.

Summary of findings

Is the service well-led?

Not all aspects of the service were well-led. The management team were not always taking appropriate action to ensure people were kept safe. There were ineffective systems in place for managing behaviour that challenged the service and pre-admission assessment processes failed to ensure that the service could meet people's needs.

Systems were in place to monitor the quality of the service and some action was taken to address any issues identified.

People using the service and their relatives were asked for their views and action was taken to address any issues raised.

Requires Improvement

The Meadow

Detailed findings

Background to this inspection

This inspection was carried out on 13 August 2014 by two inspectors, a specialist professional advisor in mental health conditions, and an expert by experience. This is a person who has personal experience of using or caring for someone who uses this type of service.

Prior to the inspection we reviewed information we held about the service. The provider had also completed a Provider Information Return (PIR). A PIR is a document that we ask providers to complete that tells us about the operation of the service, what they do to meet people's needs and any proposed improvement plans.

We used a number of different methods to help us understand the experiences of people living in the service. We spent time observing care in the communal areas such as the lounge and dining area on both floors and 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.

We spoke with 15 people who were using the service and nine visiting relatives. We also spoke with the registered manager, the regional manager for the service, the deputy manager, seven care staff, two kitchen staff, the activities coordinator and one volunteer.

We looked at records relating to people's care and the management of the service. These included eight care records, staff duty rosters, accident and incident records, complaint records, quality assurance and monitoring records, four staff recruitment files and information relating to health and safety.

We also spoke with the local authority safeguarding team and reviewed a local authority commissioning monitoring report that was completed following a visit to the service in April 2014.

Inadequate

Is the service safe?

Our findings

Most people told us they felt safe. One person said, "I have falls but they will walk with me so I feel safe" and a relative said, "I'm very confident that mum is safe here." However, we found significant shortfalls in how risks were managed at the service, in particular risks relating to behaviour that challenged the service. One person told us they stayed in their room sometimes and shut the door because someone shouted a lot and frightened them.

Prior to our inspection we spoke with a representative from the local authority safeguarding adults' team. They told us they had concerns about the way the service managed risks associated with some people's behaviour. They felt that the management team were not proactive in responding to the risks and did not sufficiently consider the impact on other people and their relatives.

Staff training records confirmed that all staff had received training in supporting people whose behaviour challenged the service. However, staff were very unclear about what they should do to protect people if a person became verbally or physically aggressive. One staff member said, "I would pull residents apart if needed" and another said, "I would call male carers to come and help." None of the staff we spoke with were able to demonstrate the appropriate skills and knowledge to assure us that they were able to safely manage behaviour that could pose a risk to others.

We looked at the incident records for the service. Some incidents of physical aggression that we found in people's daily records were not recorded appropriately as an incident and therefore any review of the incident records would not accurately reflect any patterns of behaviour or the true number of incidents occurring to ensure that effective support plans were in place. We found further inaccurate recording of incidents in people's daily records. In one person's records we saw a comment, "appeared fine all day" but an incident report showed that this person had been assaulted by another person using the service earlier in the day and there was no mention of this. Some records used to monitor people's behaviour were also incomplete.

We noted that pre-admission assessments were not always fully completed in relation to people's mental health and emotional wellbeing. For example, information had not always been sought from health and social care professionals to ascertain if the service was able to meet people's individual needs before their admission. This had led to incidents that had led to the harm of people using the service through physical aggression.

We discussed behaviour management with the manager. Although the manager told us that staff received training in this area he was unable to demonstrate how the service supported staff to adequately respond to behaviour that challenged the service. For example, support plans were inadequate as they did not provide sufficient guidance for staff to ensure they used a consistent approach that best supported the person using the service. Therefore inappropriate and unsafe care posed a risk to people who used the service.

Identified risks were assessed as part of people's care plans and included areas of risk such as falls, nutrition and risk of pressure ulcers. However, we found that risks to individuals were not always managed effectively. For example, we noticed that one person was walking around with poorly fitting shoes that increased the risk of them falling. There was nothing in their care plan that referred to this and the falls risk assessment did not include information about the importance of suitable footwear. We noted that a wound assessment had been completed by a visiting nurse. They had recorded that the wound was a possible grade three pressure sore that would require reporting as a serious incident for further investigation, however, this had not taken place. Personal emergency evacuation plans were in place for each individual but they did not contain sufficient detail to inform staff or the emergency services about people's individual requirements in the event that an emergency evacuation was required.

In two care files it was noted that observations were required every 15-20 minutes to ensure people were kept safe and their needs met. Records for these observations were incomplete and when we asked staff for the records relating to the day of the inspection they showed us blank sheets. When we queried this with staff they told us the records would be completed later in the day. Therefore these records were not being completed at the time the observations took place to accurately reflect how people were and to inform what support they needed during the day.

We looked at accident records. We noted that following one accident a person was advised to use their call bell to call for assistance in future. This was inappropriate as the

Is the service safe?

person had dementia care needs, may have been unable to follow or remember this advice, and therefore was not adequately protected from future falls. Care plans and risk assessments were not always reviewed following falls to ensure any changes in people's needs were reflected and any risks minimised. Therefore there was not sufficient information for staff to enable them to keep people safe and minimise any risks to their welfare.

The evidence above relates to breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff recruitment practices did not protect people from staff unsuitable to work with vulnerable people. We looked at recruitment records and found that inadequate checks had been completed. For example, on two of the four files viewed there was not a full employment history for the staff members and we found two references that had not been verified to check their authenticity. In another file we saw references that were dated 2009, however, the staff member had applied for their post in 2013. We also saw that a staff member's UK residence permit had expired in April 2014 and there was no evidence that this had been followed up to ensure the staff member was still eligible to live and work in the UK. This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Criminal record checks were completed for all staff and recruitment checks were completed for volunteers who supported the service.

The management team did not fully understand their responsibilities in relation to Deprivation of Liberty Safeguards (DoLS). For example, at the time of our inspection there was one DoLS authorisation in place and another application had been submitted. We noted that there were conditions in the authorisation that were not being met. In the application that had been submitted the information was unclear and did not accurately detail the restrictions that the service required agreement for to protect the person using the service and others.

In addition, we found that the service had not yet fully considered the implications of a Supreme Court ruling that had significantly changed what would be regarded as a deprivation of someone's liberty, to ensure that the service remained within the law and considered what was in the best interests of all the people using the service. For example, when we discussed this with the manager he was not aware that applications would need to be considered for all people who were unable to use the keypads to leave the units as this was a restriction of their liberty.

Limited training had taken place in relation to the Mental Capacity Act 2005 and the responsibilities of staff. Some staff were unable to demonstrate understanding of their responsibilities in relation to protecting people's rights to make their own decisions. Although there was some evidence in people's care plans that showed their mental capacity had been considered this was limited. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People using the service and their relatives commented that there were not always enough staff at busy times of the day such as in the morning and at mealtimes. There were enough staff on duty during our inspection and the staff rotas showed that the numbers of staff were adequate to meet people's needs. However, we noted that there were several days on the rotas where there were no senior carers on duty during the night. We discussed this with the manager as senior carers have responsibility for administering medicines. The manager told us that senior staff came in up to two hours prior to their shift starting or stayed on after their shift so that they could administer medicines. This meant that staff were working up to 14 hours a day on these occasions, which even with breaks meant they may not have had sufficient rest to ensure they were able to complete their duties effectively and safely. These extra hours were not included on the rota and therefore the staffing rotas did not accurately reflect the hours staff were working. When we queried this with the manager he said that staff worked the extra hours out of "good will". We also noted that shift times did not allow for a staff handover period between shifts and the manager said that senior staff stayed on to provide this. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The manager told us there were no staff vacancies at the time of our inspection and that 12 volunteers supported the service.

Safeguarding policies and procedures guided staff in relation to the action they should take to prevent and respond to allegations of abuse. Staff were able to demonstrate their awareness of safeguarding issues and all said that they would report any concerns about people's welfare to the manager. They were also aware of external

Inadequate

Is the service safe?

agencies they could report concerns to. Any safeguarding concerns were recorded centrally so that these could be monitored by the manager. Staff had received training in safeguarding adults which was repeated at regular intervals to ensure staff knowledge remained up to date.

We noted that the service had planned for foreseeable emergencies such as a loss of power supply or a flood and provided clear guidance for staff about what they should do if such an incident occurred.

Requires Improvement

Is the service effective?

Our findings

People using the service and their relatives gave mixed views about the food. Positive comments were made such as, "You get a choice, so there's usually something I like" and "They will do something else, like an omelette if you really want it" as well as "They're pretty good at producing food." Other people were less happy and told us "it's very 'samey' each day, especially the supper" and "it's the worst food I've ever had…stodge, not healthy food like I would make myself."

One relative told us that their family member's needs had changed and that they needed more support at mealtimes as a result. They told us that staff had been supportive and still encouraged their family member to do as much for themselves as possible. People were able to have their meals served in their rooms if they wished to do so.

Special diets had been catered for and kitchen staff were aware of people's needs. They were able to demonstrate how they recorded any feedback about the food and also any action taken to improve the menu based on people's views.

We observed breakfast and lunch in both units. Breakfast was staggered so that people could eat at a time that suited them. Pictorial menus were on the tables so that people could see what was being served and we observed staff discussing people's menu choices with them. People were offered a choice of drinks before the meal and staff dished up people's plates with their choice of main course and then placed dishes of vegetables on the table so people were able to help themselves and choose how much they wanted, maintaining some independence. We observed staff interacting with people and assisting them at their own pace

Care plans contained nutritional assessments and care plans. However, we found that these had not always been updated to reflect people's changing needs such as deterioration in a person's eye sight that meant they required additional equipment to support their continued independence.

The home had a policy of monitoring people's weight on a monthly basis as any significant changes could indicate ill health. However, we found gaps in people's weight monitoring records. One person's care file stated that the person had a poor diet and this had resulted in significant weight loss. A referral to a dietitian had been made who had advised that the person's weight should be monitored every two weeks. We noted that this person had not been weighed for a month. Also, we saw a record of a telephone call with the dietician that resulted in their input and the supply of supplements ending but there was no evidence that this person had gained any weight. The manager gave us a possible explanation for this but was unsure of the reasons why.

Some people had food and drink charts in place to monitor their nutritional intake. However, we found gaps in these records which indicated that people's nutritional needs were not sufficiently monitored. One person's care plan stated that they should be given food and drink little and often to encourage them to eat more but when we looked at their food and drink charts we saw that this had not been the case. The records indicated that monitoring had stopped but staff were unable to verify this and the care plan had not been updated to reflect any changes. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were referred to healthcare specialists where required. For example, people had been referred to the district nurse and a speech and language therapist when staff had identified a health need or potential risk such as a risk of choking. We saw records relating to GP visits, dental health checks, eye tests and foot care provision. People had also been referred to mental health specialists where a need had been identified. People could arrange to see healthcare professionals of their choosing where they had the capacity to make this decision for themselves.

Staff told us they received a two week induction to the service and the records we saw confirmed this. They said they also shadowed more experienced staff members and completed mandatory training to equip them with the skills and training to meet people's needs. The training records showed that staff had completed mandatory training in topics such as moving and handling, health and safety, fire safety, infection control and safeguarding. However, when we looked at some staff member's training certificates we noted that they had covered up to seven training topics in one day using e-learning. This raised questions about the quality of the training received as staff would not have time in one day to cover enough detail in each of the topics to

Requires Improvement

Is the service effective?

equip them with adequate knowledge. Prior to our inspection a local authority representative had also raised concerns about staff understanding of dementia care needs.

The manager told us that moving and handling, dementia training and training around behaviour that challenged the service were group training with a facilitator during which staff could practice practical skills and ask questions about the topic.

Staff told us that they had regular one to one meetings with their manager and said that they received annual appraisals where their performance was assessed and any further training needs identified. We saw records that confirmed this. These processes helped to support staff with their responsibilities of providing care to people.

Requires Improvement

Is the service caring?

Our findings

People using the service and their relatives spoke positively about staff and the care they received. Comments included, “Staff are very caring”, “We are treated well” and “They are very helpful and very pleasant.” One relative said, “The carers are amazing, [my relative] likes them, and they seem genuinely fond of her.”

We observed staff to be warm and pleasant in their interactions with people. For example, we saw staff chatting with people in a friendly manner and bending down to talk with them at their level. At mealtimes we saw that staff were attentive to the people they were supporting and we observed staff encouraging people to do things for themselves such as taking cups back to the kitchen and folding their own clothes to try and maintain their independence.

The volunteer we spoke with told us that they spent time talking to those people who did not have many visitors. We observed this volunteer encouraging a person to come out of their bedroom to join a group activity to prevent them becoming isolated.

People told us their privacy was respected and in general we observed staff taking steps to ensure people’s privacy and dignity was maintained. However, we observed one occasion where someone’s personal confidential information was not respected. In the dementia care unit there was an area of the dining room that was used as an office for staff. We heard a member of staff discussing someone’s catheter management where any people using the service or visitors would be able to hear.

People’s rooms were very personalised and people had been encouraged to bring their own furniture and other personal possessions into the home such as photographs, ornaments, books, plants and music systems. Several people told us that they read a lot and listened to music and enjoyed tending to their plants. One person said, “I know I can’t look after myself anymore, but here I do just what I used to at home.”

People had a copy of their care plan in their bedroom, however, we saw limited evidence that people had been involved in planning their care. For example, many care plans had not been signed by people using the service or their relatives and there was no record of any discussions that had taken place when deciding how people’s needs were to be met. Two relatives we spoke with said they had been involved in the care plan for their family member when they first arrived at the home but had not been involved since. However, they told us that they were kept informed about any changes to their relative’s needs. One person told us that one member of staff asked them questions about how they were feeling when they were writing in their notes.

The service is operated by a Methodist organisation and the majority of the people using the service were Christians. The manager told us that the service could accommodate people of other faiths but there was no-one of another faith using the service at the time of our inspection. Volunteers who supported the service carried out bible readings, Christian services and supported people to attend church.

Requires Improvement

Is the service responsive?

Our findings

We saw from a report completed following a local authority monitoring visit in April 2014 that concerns had been raised about the service's pre-admission assessment process. There were completed pre-admission assessments in people's care files but some of these were very brief and did not contain sufficient detail to inform people's care plans so that their individual needs could be met effectively. For example, we saw comments such as 'walks with frame' and 'needs some assistance' that described people's mobility needs, with no further detail about what help people required or what tasks they could be supported to do themselves. We were not assured that the assessment process was detailed enough to minimise the risk of inappropriate or unsafe care to the person.

Care records were very task oriented and did not fully consider people's preferred routines and their likes, dislikes and interests. We saw some information relating to people's life histories, however, this was inconsistent. Therefore there was a risk that staff were not equipped with adequate information about people's lives to support positive relationships that embraced people's identities and the people and experiences that were important to them. Care plans did not always contain sufficient information to effectively guide staff about how to meet people's individual needs.

Staff completed a record each day that stated whether people had received support with a wash, shower or bath. We noted in three people's records that they had not had a bath or shower for over a year and were only supported to have a wash. When we queried this with staff they could not explain why this was the case. It was not because the people were unable to have baths or showers and it was not a personal preference they had made. In addition, there was no information in their care plan detailing their preferences in relation to personal care. There were not continence assessments and management plans in place for a person who used a catheter. We also noted there were gaps in charts that were used to record that two people had been turned at specified intervals to prevent pressure ulcers developing. People's care plans were reviewed monthly but had not always been updated to reflect people's changing needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw that relatives were involved in some care plan reviews and people using the service or their relatives had signed consent to people accessing their care plan, outings and having their photograph taken. However, many people's care plans had not been signed by either the person using the service or a family member to evidence that they had been involved in planning their care.

People told us that staff came quickly if they called for help using their call bell or the call pendant that some people wore. People also said that they could choose to lock their door if they wanted to as it made them feel safer at night and staff told us that they had agreed with people that they would open their doors during the night and check on them.

Annual surveys were completed to gain feedback from the people using the service and their relatives. The most recent survey had resulted in comments about the lack of time staff spent speaking with people on a one to one basis. As a result the manager had introduced one to one key work sessions to improve this. However at the time of our inspection there was no record of these meetings taking place and the manager told us that the system had not yet been formalised.

We noted that staff were very busy and had limited opportunity to interact socially with people in the dementia care unit. Staff told us they did not have time to engage in activities with people and said that this was left to the activities coordinator and other visitors to the service. People made positive comments about the activities coordinator and told us they took part in newspaper discussions, crossword groups and said they were supported to access the community. We observed a game of table tennis taking place which people were enjoying and one person said, "time flies." A music therapist attended the service weekly, providing one to one sessions and group work in the dementia care unit and they were present on the day of our inspection. The manager told us a reflexologist also visited the service weekly. We saw an activities timetable that also included activities such as bible study, gardening and cake making as well as visits from a local Brownie group, a choir, a brass band and first world war tea dancers.

Special occasions were celebrated and several people mentioned a party that had been held for someone's 101st birthday. We were shown photographs of this occasion and a write up in a local newspaper.

Requires Improvement

Is the service responsive?

People confirmed that friends and relatives were actively encouraged to visit the service and take people out. We observed that staff made visitors welcome and addressed them by their name. Relatives told us that they felt welcome and were given refreshments. Five of the people we spoke with had telephones in their room so that they could easily keep in touch with friends and family.

People told us they would have no hesitation in commenting if there were things happening that they didn't like. One person said, "I have nothing to complain about….If I want anything I can ask." One relative told us they had 'grumbles' when their family member first moved into the service but said staff had been responsive and things had been sorted out. They said, "What is good is they listen if you have a problem and are open about discussing it with you."

There was a complaints procedure in place and information about how to make a complaint was included in the information given to people when they moved into the service. There was a complaints leaflet available in the reception area of the service as well as a suggestion box. We noted that there was not clear, accessible information on the units to remind people how to raise any concerns they had.

The complaints record included a summary of the complaints for each month. We saw that complaints had been responded to promptly by the manager in writing and issues addressed. The manager gave an example of how changes had been made to the evening meal as a result of comments made by a relative.

There was information about an independent community advocacy service displayed in the reception area of the service that people could access if they needed independent support and advice.

Requires Improvement

Is the service well-led?

Our findings

The management team did not adequately ensure the safety of people who used the service. There were ineffective systems in place for managing behaviour that challenged the service and pre-admission assessment processes failed to ensure that the service could meet people's needs before they moved into the service.

At the start of our inspection we asked the manager about any challenges that the service was facing. He told us the service was not facing any particular difficulties. During our inspection we found evidence of several issues impacting on people using the service, including inconsistent management of behaviour that challenged the service, poor record keeping and insufficient consideration of people's mental capacity to ensure their rights were protected.

We saw that audits were completed on a monthly basis to monitor the operation of the service. For example, 10% of care plans were audited each month, first aid boxes were checked and a visual check of the kitchen was completed. Accidents and incidents were analysed monthly to see if there were any patterns or issues that needed to be addressed. Other health and safety audits were completed covering areas such as manual handling, fire, the environment and infection control. There was also a quality team that the provider employed to monitor the operation of the service at regular intervals. We saw that some issues had been identified and action taken to address these.

We saw meeting minutes from several staff meetings and found these mainly involved the manager passing on information to staff rather than involving them in the development of the service which staff confirmed as their experience. These meetings took place monthly and included topics such as reminders about record keeping, completing monthly care plan updates, training and ensuring prompt responses to emergency call bells. However, staff told us they felt supported by the management team. One staff member said, "If we need help, they are always here." Staff also confirmed that they had regular one to one meetings with their manager and felt able to raise any concerns.

Monthly meetings were taking place to gain feedback from people who used the service. Some of the people we spoke with attended these meetings and told us they felt comfortable about expressing their views and making suggestions, which sometimes changed things. One person told us the food had changed as a result of their comments but another said, "It usually doesn't change anything." One person told us they had been given a satisfactory explanation as to why they had been left waiting for assistance for a long time one night.

Relatives meetings also took place at regular intervals. A relative told us they used to attend these meetings and felt that the meetings sometimes had an effect. They told us they now raised any issues by phone or email and said the manager responded promptly to this.

A volunteer told us that they had meetings a few times a year as a group to discuss their role in the service. They said there was a supervisor who organised the meetings and monitored the volunteers but said that the manager also attended the meetings.

We saw that annual satisfaction surveys were completed and the results analysed to inform improvements to the service. In the 2013 survey some people had commented that staff did not spend enough time talking with them. As a result of this the manager had introduced one to one key work sessions but we found these were not taking place despite these being introduced several months before. The manager said this would be addressed.

We found some information in the service's Statement of Purpose misleading. For example, the document stated that the service had specialist dementia advisors available to provide support for people with dementia care needs. However, when we queried this with the manager he told us that they seek the support of outside organisations and that there were not dementia specialists employed by the service. The manager told us the service had formed links with the Alzheimer's Society but we were unable to verify this during our inspection.

People using the service told us the manager walked round the home each day to see what was happening. One relative commented, "He seems very fond of mum, she knows he's the boss and she likes him."

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving unsafe or inappropriate care as they had not taken action to fully assess and meet the service user's individual needs and ensure the welfare and safety of service users. Regulation 9(1)(b)(i) and (ii)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The registered person was not operating effective recruitment procedures as they did not ensure all information specified in Schedule 3 was available. Regulation 21(a) and (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. Regulation 18**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

This section is primarily information for the provider

Action we have told the provider to take

The registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. Regulation 22