Carebase (Histon) Limited

Bramley Court

Inspection Report

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Overall summary

Bramley Court is a care home providing accommodation and nursing care for up to 67 adults. There were 65 people living there when we visited. The care home provides a service for people with physical nursing needs and for people living with dementia. A registered manager is in post.

People did not raise any concerns about their safety in the home and we saw there were systems and processes in place to protect people from the risk of harm. Staff were recruited through robust recruitment practices.

People were protected against the risk of unlawful or excessive control or restraint because the provider had made suitable arrangements for staff to respond appropriately to people who communicated through their behaviour.

Where people lacked capacity to make decisions, the Mental Capacity Act 2005 was not being fully adhered to, to ensure staff made decisions based on people's best interests. For example, where some key decisions, such as the use of bedrails had been made, there had not been an assessment completed to determine whether each person had the capacity to understand these decisions and that the decisions were in their best interest.

There were not always enough staff to meet people's needs on the nursing unit. This was a breach of Regulation 22 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2010 and you can see what action we told the provider to take at the back of the full version of the report.

There were processes in place to gain the views of people in relation to their care and support. People's preferences and needs were recorded in their care plans and staff were following the plans in practice. Records and observations showed that the risks around nutrition and hydration were monitored and managed by staff to ensure people received adequate food and drink.

We observed interactions between staff and people living in the home and staff were kind and respectful to people when they were supporting them. People were supported to attend meetings where they could express their views about the home.

Complaints were responded to appropriately and we observed staff responding to people's needs. The top floor of the home was well set out for people with a dementia-related illness and provided an engaging environment to live in.

There were systems in place to monitor and improve the quality of the service provided. Meetings were held for people using the service, relatives and staff and actions were taken in response to issues raised. Action plans, in response to audits and incidents, and the following up of these ensured continuous improvement. Staff were supported to challenge when they felt there could be improvements and there was an open and transparent culture in the home. However, these systems had not identified some shortcomings in records and that there weren't enough staff to meet people's needs at all times.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS), and to report on what we find. The deprivation of liberty safeguards are a code of practice to supplement the main Mental Capacity Act 2005 Code of Practice.

We looked at whether the service was applying the DoLS appropriately. These safeguards protect the rights of adults using services by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are trained to assess whether the restriction is needed. The manager told us there was no one living in the home currently who needed to be on an authorisation. We saw no evidence to suggest that anyone living in the home was being deprived of their liberty. We found the location to be meeting the requirements of the DoLS.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

There were not enough staff to support people safely, especially on the nursing unit. People using the service, their relatives and staff told us there were not enough staff on this unit to meet people's needs at all times. We also observed this to be the case. This was a breach of Regulation 22 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2010 and you can see what action we told the provider to take at the back of the full version of the report.

Staff were recruited in line with safe recruitment processes. People were protected from the risk of abuse because there were clear procedures in place to recognise and respond to abuse and staff were trained in how to follow the procedures.

Where people displayed behaviour which may challenge others, there was detailed guidance for staff to follow in relation to what may trigger the behaviour and how to respond. Incidents in the home were recorded by staff, assessed by the manager and action was taken in response to most incidents. However, the incident forms did not always contain full details of actions taken and we saw two examples of people who had fallen but their risk assessments had not been reviewed in response to the falls.

We saw that the Mental Capacity Act 2005 was not fully adhered to. We saw that full assessments of capacity and best interests' decision making had not been carried out in relation to three people who had bedrails. We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards.

Are services effective?

Care plans gave details of people's preferences in relation to the way they liked to be cared for and supported. Staff we spoke with had a good understanding of people's likes and dislikes and how they would prefer to be supported. We observed staff provided care to people in line with their preferences.

Three people told us that they had not seen and were not fully aware of their care plans. However, we saw examples where people and their relatives had been involved in care planning. Care plans were in place to manage the risk of developing a pressure ulcer. We saw that guidance was detailed and staff were observed to be following this in practice. However, recording of positional changes to reduce the risk of pressure ulcers was not consistent so it was not

Summary of findings

always clear whether people had been given support at all times to reduce their risk. We also saw that additional guidance and documentation needed to be put in place to provide full guidance to staff on supporting a person with epilepsy.

The risks around people's nutrition and hydration were monitored and managed. People's views on the quality of food were mixed. One person needed support with their nutrition and we saw there were plans in place so that staff understood how to support this person. Records showed staff were monitoring the risk to this person in practice and supporting the person with their nutrition, hydration and risks around choking. However, while staff were noting people's fluid intake they were not comparing this intake to the target fluid intake for those people. This meant that there was a greater risk that staff would not identify when a person was failing to receive sufficient fluid intake.

Are services caring?

We observed interactions between staff and people using the service on the day of our visit. We saw staff engaged positively with people, showing them kindness, compassion and respect. We observed staff in the dementia unit. We saw staff were very caring and patient with people. Staff showed kindness to the people they supported and we saw this had a positive impact on them.

Independence was promoted with people being supported to do things for themselves and participate in daily living tasks. We saw people moving freely around the home during our visit and staff told us people did not have unnecessary restrictions placed on them. There were regular meetings held between the manager, staff and people using the service. These were used to discuss activities and raise concerns and any issues that people may have.

Are services responsive to people's needs?

There were monthly meetings held with staff and people who lived in the home. The home took action in response to issues raised by staff and people who used the service. This meant people were supported to give their views on their care and support and the service responded to them.

We saw that complaints processes were in place and complaints were handled appropriately by the service.

Staff responded appropriately to people's needs and the environment for people with dementia-related illness contained a lot of areas and activities to engage them. Staff on this unit were encouraged to eat their meals with people using the service to stimulate social engagement with them.

Summary of findings

Are services well-led?

We spoke with two members of staff and they both told us they felt the management team treated them fairly and listened to what they had to say. One member of staff told us they felt confident to challenge decisions made about the service and that this was respected and changes made or a reason for the decision given.

There were regular meetings held for people who used the service, relatives and staff. Actions were identified and taken in response to issues raised. We also looked at the processes in place for monitoring incidents, accidents and safeguarding. A range of audits were carried out to assess the quality of the service. This showed that there were procedures in place to monitor and improve the quality of the service provided.

Staff we spoke with told us they were provided with the right training and support to ensure they had the skills and knowledge they needed. We saw that appropriate induction, supervision and training were provided to staff. There was a system in place to assess the dependency of people using the service to consider how many staff were needed to care for them. However, we found on the day of inspection that there were not enough qualified, skilled and experienced staff to meet people's needs on the nursing unit.

Summary of findings

What people who use the service and those that matter to them say

We spoke with eight people who used the service.

We asked people about staffing levels at the home. One person told us that they often had to wait 40 minutes to get out of bed in the morning as they needed help with getting up and going to the toilet. They told us that this often meant having an accident which was upsetting. Another person thought the home was understaffed but that they were helpful and supportive and gave them their dignity.

We asked people what they thought about the food provided at the home. Three people told us the meals were "fair". They told us that it felt like they were constantly having soup offered to them for lunchtime and tea and it was becoming "a drudge". Another person told us that the food varied in quality but that they were well fed.

One person told us that the food was "not too good" although it had improved. They told us that they were allergic to fish and, 'make do with an omelette'. They told us that for the price they paid for their care they were very dissatisfied. One person told us that they often woke up early and would like a cup of tea while waiting for breakfast, but were unsure whether they could ask for this.

We asked people what they thought about the care provided by the home. One person we spoke with said, "On the whole it is very good here. It is difficult to fault it." One person told us that the caring, "was excellent and it makes you feel needed." They told us that the staff were approachable. Another person told us that the care was good and said, "They keep me clean and tidy." Another person said, "They have a good team on this floor."

Three people told us they had not seen and were not completely aware of what a care plan was.

We asked people who they would talk to if they had any concerns. Two people told us that if they had any issues they would speak to their families who would complain on their behalf. They said they were concerned about "being a nuisance" and that they were uncertain who to complain to.

We also observed a meeting of people who used the service. About 12 people attended the meeting. One person commented that they had asked for a new bed a month ago and, "it was a long time coming." Some comments were made that the "food is dry and not enough gravy". There were also issues raised about laundry with items going missing.

We spoke with six relatives.

Three relatives told us their relative was safe.

One relative said, "There are not enough carers." The other relative said, "Sometimes there are not enough staff, but they are very kind." Another relative told us that staff were friendly but they were very concerned about their relative's care. They told us that staff were harassed and didn't have time to sit with their relative who they often found on their own and they felt this was due to staff shortages.

Two relatives told us that their relative was treated kindly, "kindness, absolutely". They told us that when a doctor was called to their relative, that this was done quickly and they were informed as next of kin. They said their relative was able to choose what they wore and when they wanted a bath or a haircut.

Another relative told us that they thought their relative was depressed. They felt that the manager, who they had approached about a befriending service, had not carried out their wishes.

Bramley Court

Detailed findings

Background to this inspection

We visited Bramley Court on 15 April 2014. We spent time observing care and support in the lounge on the dementia unit. We looked at all communal areas of the building including kitchens, bathrooms, lounges and people's bedrooms. We also looked at some records, which included people's care records and records that related to the management of the home.

The inspection team consisted of a lead inspector, another CQC inspector and an expert by experience of older person's care services. An expert by experience has personal experience of using or caring for someone who uses this type of care service.

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 was meeting the Regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process for adult social care called 'A Fresh Start'.

Bramley Court was last inspected on 17 April 2013. There were concerns found at that inspection regarding the content of care plans, recruitment procedures and complaints handling and the security of records.

Before our inspection we reviewed all the information we held about the home. We examined notifications received by the Care Quality Commission and we contacted the commissioners of the service to obtain their views on the service and how it was currently being run.

On the day we visited we spoke with eight people living at Bramley Court, six relatives, four staff and the registered manager.

Are services safe?

Our findings

When we inspected the service in November 2013, we found concerns in relation to the home's recruitment procedures. We asked the provider to send us an action plan and tell us what they would do to make improvements.

We spoke with two staff about the recruitment practices in the home. They told us that staff were not permitted to start work until safety checks, such as a criminal records check and references were received. They said that staff were then safe to start working in the home and were given an induction and shadowing until they could safely support the people in the home

We looked at three recruitment files for staff most recently recruited by the service. The files

contained all relevant information and the service was carrying out all appropriate checks before a staff member started work. These checks included references and a Disclosure and Barring Scheme check. This demonstrated that the service operated robust recruitment procedures to make sure that the staff they employed were suitable to work with vulnerable adults.

The provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening to protect people living in the home from the risk of abuse. Staff told us they had received recent training in safeguarding vulnerable adults and records confirmed this. We spoke with two members of staff and they were able to tell us how they would respond to allegations or incidents of abuse and they knew who to report these to in the organisation. The registered manager told us there had been no recent safeguarding incidents in the home. People we spoke with did not raise any concerns about their safety and three relatives told us that their relative was safe.

We looked at the care records for a person who displayed behaviour that may challenge others. We saw that there were risk assessments in place, supported by plans which detailed what might trigger their behaviour, what behaviour the person may display and how staff should respond to this. We saw that the information was held in various support plans and would benefit from being condensed together in one specific plan. The manager told us that restraint was not used in the home. Three people told us that they were free to move around the home and into the garden. This meant that people who used the service were protected against the risk of unlawful or excessive control or restraint because the provider had made suitable arrangements.

We saw that where incidents did occur in the home, these were clearly documented by staff and checked by the manager, who assessed if any investigation was required, and who needed to be notified. However, it was not always noted what action had been taken in response to incidents. We saw that one person who had fallen four times in the last month, had not had their risk assessment reviewed in response to each fall and when it was reviewed the person was assessed as 'low risk'. A body map had also not been completed to detail the injuries received by the person and to support monitoring of their injuries to ensure they continued to heal. The person had received appropriate medical attention in response to their falls. We saw that another person had also not had their falls risk assessment reviewed in response to falls. However, again the person had received appropriate medical attention and the incidents were clearly documented by staff. This meant that the service did not always ensure that risks were assessed promptly and accurately, so that appropriate actions could be taken to minimise the risk of future falls.

Staff we spoke with told us they had received training in relation to the Mental Capacity Act (MCA) 2005. This is an act introduced to protect people who lack capacity to make certain decisions because of illness or disability. The two staff we spoke with had a good understanding of the MCA and described how they supported people to make decisions. We saw that staff supported people to make their own decisions where they had the capacity to do so.

We saw from the care plans of three people that an assessment of their capacity had been completed. However, where some key decisions, such as the use of bedrails had been made, there had not been an assessment completed to determine whether each person had the capacity to understand these decisions and that the decisions were in their best interest.

We looked at whether the service was applying the Deprivation of Liberty safeguards (DoLS) appropriately. These safeguards protect the rights of adults using services, by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are

Are services safe?

trained to assess whether the restriction is needed. The manager told us there was no one living in the home currently who needed to be on an authorisation. We saw that people who lived in the

part of the home designed for people living with dementia, had all been assessed as part of a screening to ensure they did not require a DoLS authorisation. Some of these assessments had not been reviewed for some time. Reviewing them would ensure the information was up to date. We saw no evidence that anyone living in the home was being deprived of their liberty. We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards.

We looked at whether appropriate staffing arrangements were in place. One person told us that they often had to wait 40 minutes to get out of bed in the morning as they needed help with getting up and going to the toilet. This often meant having an accident which was upsetting. They also told us that often there were only two staff working in the morning when there should have been four. Another person thought the home was understaffed but that staff were helpful and supportive and gave them their dignity.

Observations and speaking with staff, provided evidence that staffing levels in the area of the home where people with a dementia-related illness lived were adequate. However we found that the staffing levels were not always adequate to meet the needs of the people living in the nursing area of the home.

We visited this area in the afternoon and we found one person in their bedroom who was calling out for staff. We rang the nurse call alarm for this person and whilst we waited for staff to arrive we spoke with this person, who told us they were waiting to get onto their bed for a rest. We asked if they usually had to wait long for staff if they needed them and they said, "It depends on what they [staff] are doing." We observed it took six minutes for staff to respond to the nurse call alarm and then when the member of staff arrived they told the person they were assisting another person and would come back. This took a further five minutes. This meant people sometimes had to wait for staff to give them the support they needed.

We spoke with four staff and two relatives in the nursing area of the home and we asked them about levels of staff in relation to meeting the needs of people living there. One relative said, "There are not enough carers." The other relative said, "Sometimes there are not enough staff, but they are very kind." All of the staff we spoke with told us they felt sometimes more staff were needed.

We looked at the needs of the people living in the nursing area of the home and the staffing levels. Staff told us there were usually five carers and one nurse to provide care to 22 people. We were told that 19 of these people needed two members of staff to provide personal care such as getting washed, dressed, bathed and going to the toilet. One person needed the support of 4 staff to transfer them to the toilet or to have personal care. Staff told us sometime the staffing levels dropped to less than the planned six if staff called in sick and cover could not be found. This meant that there were not always enough qualified, skilled and experienced staff to meet people's needs. This meant that there had been a breach of the relevant legal Regulation (Regulation 22) and the action we have asked the provider to take can be found at the back of this report.

Are services effective?

(for example, treatment is effective)

Our findings

The last time we inspected this home in November 2013, we asked the provider to make improvements in relation to risk assessments and care planning. We checked at this visit to see if the improvements had been made. We found that in the area of the home where people living with a dementia related illness lived, care plans were now being regularly reviewed and were reflective of people's current needs.

From the care plans we viewed, we saw that people's preferences and wishes about how they were cared for were documented to ensure staff knew how people liked to be cared for. We spoke with staff about the needs and preferences for these people and what staff told us matched the information we had seen recorded in the three care plans. For example, one person preferred to have their drinks from a beaker with a lid on and we observed this happen in practice. This meant staff had the information and knowledge to be able to care for people in their preferred way.

We saw that staff had involved people's significant others in the implementation and reviews of their care plans. There were signatures of people, consenting to the information in the plans and there were copies of letters sent out to people inviting them to the reviews. However, three people told us they had not seen and were not completely aware of what a care plan was.

One person we spoke with said, "On the whole it is very good here. It is difficult to fault it." We saw that details of an advocacy scheme were available for people who used the service and the registered manager told us that some people were being supported by advocates.

Where people had been assessed as being at risk of developing a pressure ulcer, there were risk assessments and plans in place informing staff of how to manage the risk to minimise the risk of these developing. We looked at the steps staff had taken to minimise the risk and we saw staff had followed the plans in practice. For example, where people needed to sit on pressure relieving equipment, we saw this was being used and their skin was checked regularly. We found that although the day staff had recorded when they had supported people to change position, the night staff had sometimes left gaps, which meant it was not clear whether people were being given the support they needed at all times.

We saw that one person had a health condition which caused them to have seizures. There was a care plan in place in relation to the medication to be used and how staff were to respond to the seizures. There was also information informing staff of what signs the person may display prior to and during a seizure. The plan did not specify at what point to call the emergency services. Staff had also not used a specific seizure monitoring record. The use of a specific record would enable staff to see if seizures were increasing or decreasing and so determine if the treatment given was effective.

We checked to see whether people were protected from the risks of inadequate nutrition and dehydration. Three people told us the meals were "fair". They told us that it felt like they were constantly having soup offered to them for lunchtime and tea and it was becoming "a drudge". Another person told us that the food varied in quality but they were well fed.

One person told us that the food was "not too good" although it had improved. They told us that they were allergic to fish and, 'make do with an omelette'. They told us that for the price they paid for their care they were very dissatisfied. One person told us that they often woke up early and would like a cup of tea while waiting for breakfast but were unsure whether they could ask for this.

We saw from the care plans of two people that they had specific needs around their nutrition due to a risk of weight loss. Staff had put in place a risk assessment, a detailed care plan and were monitoring both people's food intake and weight. We saw from the care plan of one person that they had specific needs around their nutrition due to a risk of choking. We observed the needs detailed in the person's care plan were followed in practice during the day. We saw staff had put in place a risk assessment and a detailed care plan to manage this risk. External health

professionals had been involved in assessing the risk to this person. This meant there were processes in place to monitor and manage nutritional risks.

People were provided with a choice of suitable and nutritious food and drink. During our observations we saw people were given snacks in between their meals and

Are services effective?

(for example, treatment is effective)

drinks were offered throughout the day. Where there was a risk of dehydration we saw staff were recording how much fluid people were consuming each day. However, staff were not totalling these amounts to compare them against the recommended intake for individuals. This meant that there was a greater risk that staff would not identify when a person was failing to drink enough.

We observed lunch being served to people and saw they were given a choice and were supported to express their preference. In the residential and nursing areas of the home, there was a menu displayed for people to make their choice from. In the area of the home where people with a dementia-related illness lived, staff offered a visual choice to people at lunch. This demonstrated that people were supported to make choices about what they ate.

Are services caring?

Our findings

One person told us that the caring, "was excellent and it makes you feel needed." They told us that the staff were approachable. Another person told us that the care was good and said, "They keep me clean and tidy." Two relatives told us that their relative received compassionate care. They said, "Kindness? Absolutely."

We observed staff in the area of the home where people with a dementia-related illness lived. We saw staff were very caring and patient with people. Staff showed kindness to the people they were supporting and we saw this had a positive impact on people. For example, a member of staff approached one person and said, "You look lovely today. Are you OK?" They then sat with the person and gave them a hug, which the person responded to positively, by smiling and talking to the member of staff.

There was a relaxed and calm atmosphere in the Dementia unit. We saw there was a culture of staff giving hugs, kisses and making positive comments to people. Although throughout our observations this appeared to have a positive impact on people, people may not always be receptive to this affection and this should be taken into consideration.

We saw that a weekly church service was held in the home and holy communion was also available for people using the service. This meant that people's religious needs could be met while living in the home.

From the care plans we viewed, we saw that people's preferences and wishes were documented to ensure staff knew how people would like to be cared for. We spoke with staff about the needs and preferences of these people and what staff told us matched the information we had seen recorded in the three care plans.

During our visit we saw staff respecting the privacy and dignity of people who lived in the home. For example, staff knocked on people's doors before entering bedrooms and closed doors when assisting or supporting -people with personal care. We spoke with two staff about how they would respect a person's privacy and dignity and both had a good understanding of how they should

support people with this.

Staff told us they supported people living with a dementia-related illness to be independent and involved in daily living tasks around the home. We saw evidence of this with one person being supported to help staff clear up after a meal in the kitchenette. This showed that people were supported to enable them to be as independent as possible.

The registered manager told us that there were no people receiving end of life care within the home. They told us that they had close links with the local hospice who provided them with training. We saw that care plans included sections for end of life care arrangements.

There were regular meetings held between the manager, staff and people living in the home. These were used to discuss activities, and to raise concerns or any issues people had. This meant people were supported to make their views known about the service. We also saw that regular relatives' meetings also took place.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

When we inspected the service in November 2013, we found concerns in relation to the home's complaints process and its handling of complaints. We asked the provider to send us an action plan and tell us what they would do to make improvements.

Two people told us that if they had any issues, they would speak to their families who would complain on their behalf. They were concerned about "being a nuisance" and that they were uncertain who to complain to.

The home's complaints' procedure had been updated and reflected updated legislation and the CQC's address. It did not have the local authority's contact details for those people whose care was funded by the local authority or the ombudsman's details. The home's complaints' policy however, contained these details. We looked at recent complaints and saw that they had been responded to appropriately.

We saw notes of monthly meetings that took place of people who lived in the home. Action plans were produced following these meetings and progress on these actions were discussed at the next meeting. This demonstrated that people were supported to give their views on their care and support.

Due to the complex needs of some people living at Bramley Court they were unable to talk with us. We therefore 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 carried out this observation for a period of 40 minutes during the morning.

We observed the experience of four people and the interactions from staff. The four people we watched had a positive experience with all of them engaged in a task or activity throughout the 40 minutes. During the first 20 minutes, one person was watching a television programme about warships, two people were reading a book and the fourth was having a drink and a snack. There

were frequent short positive interactions from staff, supporting the people to engage in their activity or task.

During the last 20 minutes of the SOFI an entertainer visited the home and all four people we were observing were supported to engage in the armchair exercises to music. We saw this was a positive experience for the people, with them smiling and getting involved in the activity.

Staff used the 'butterfly' approach, which is a recognised approach to providing short stimulation to people who have a dementia-related illness. We saw this approach had a positive impact on people living in this area of the home and throughout the day people were seen to be relaxed, happy and content.

The environment in this area of the home was detailed with a range of areas and activities which designed to engage and stimulate people living with a dementia related illness. There was a sensory room, which was in operation with a range of soothing lights for people to go into if they were passing or if they wanted to sit and relax.

Staff were encouraged to sit and eat their meals with people living in the area of the home designed for people living with a dementia related illness. Staff told us they were provided with a free meal and on the understanding they ate it with people living in the home and used it to stimulate social engagement with people.

The registered manager told us that a risk assessment was carried out to assess people at risk of social isolation and activities care plans were in place to minimise these risks. There was an activities schedule displayed in the home and the weeks activities included, musical movements, an Easter bonnet and ice cream party, a film afternoon and an Easter church service.

Are services well-led?

Our findings

The staff we spoke with told us that the management team were approachable and that they felt supported. They told us they were given the training they needed to do their job safely and that they were given the opportunity to have a formal supervision meeting with their manager or team leader regularly. The registered manager told us that staff were made aware of the whistleblowing policy during their induction training and that it was also a question asked of applicants at interview. We saw evidence of an investigation carried out in response to concerns raised by staff. This meant there was an open and transparent culture in the home where staff were supported to raise concerns.

Values in relation to dignity and independence were evident through discussions with staff, information displayed, records and our observations throughout the day. The registered manager told us that staff were made aware of the values of the organisation through the induction and supervision process.

People who used the service were asked for their views about their care and treatment and they were acted on. We saw that actions were taken in response to issues raised at monthly meetings of people who used services. We also saw that regular relatives and staff meetings took place. This meant that there were processes in place to gather views on the service and respond to any issues to improve the service. However, a relative told us that they thought their relative was depressed. They felt that the registered manager, who they had approached about a befriending service, had not carried out their wishes. We raised this with the registered manager on the day of the inspection.

The registered manager told us that they were responsible for investigating all complaints and that these were regularly audited. Learning from complaints was discussed at staff meetings. They told us accidents and incidents were audited monthly and individual incidents were investigated and the local authority and CQC would be notified where appropriate. We saw accident and incident forms included appropriate detail and some, but not all forms, included actions that had been taken in response to them. This meant there were effective arrangements to continually review safeguarding concerns, accidents and incidents and the service learned from these.

We saw that the home also completed a number of audits. All care plans were audited every month to make sure that they were accurate and that the records were being completed properly. The manager audited the care plans and made comments where improvements were required. The home manager also completed a monthly audit which looked at areas such as medication, incidents, accidents, Human Resource (HR) files and dignity. The last audit scored the home at 95% and included an action plan to address any identified issues. We also saw that an outside organisation had recently carried out an audit of the home. Although care plans were being audited by the management team, there were some gaps in the recording of people being supported to reposition where there was a risk of them developing a pressure ulcer. We raised this issue with the registered manager.

The registered manager told us that each person was assessed for their level of dependency. These scores were totalled and used to determine how many staff were required. They told us that the dependency scores were audited annually and staffing levels could be modified as appropriate. This meant that a system was in place to assess and monitor whether there are sufficient numbers of staff to meet the needs of people. However, we found on the day of the inspection that there were not sufficient staff. This meant that the system was not effective.

We spoke with two members of staff about how they would respond to concerns raised by people living in the home or their relatives. Both knew that they should record the concern and immediately pass the information on to the management team.

The registered manager told us they met with managers from the other homes owned by the provider. They met every two months and at training days. They told us this was a good opportunity to share practice and receive support.

The registered manager told us that staff received an induction and would now be following a common induction workbook that the local authority asks its staff to complete. We saw a record of the training that staff had completed. This showed that around 90% of staff were up to date with their training. We checked the record against a sample of four HR files and it was accurate.

We saw examples of supervisions and appraisals. Appraisals of staff with management responsibilities

Are services well-led?

included feedback from the staff they were managing. 42 of 70 staff had received an appraisal and 40 of 70 staff had received supervision since January 2014. The registered manager told us that all staff would have received an appraisal by the middle of the year. This meant that staff were appropriately supported to meet the needs of people.

The service had achieved accreditation from Dementia Care Matters. Their dementia service had also reached the final of the national care awards.

There were plans in place for emergency situations such as an outbreak of fire. Staff understood their role in relation to these plans and had been trained to deal with them.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Staffing** The registered person did not take appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.