ARMSCARE Limited

Docking House

Inspection report

Station Road
Docking
Kings Lynn
Norfolk
PE31 8LS

Tel: 01485518243
Website: www.armscare.co.uk

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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

This inspection took place on 14 and 16 November 2016 and was unannounced.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Docking House provides accommodation and personal care for up to 39 older people, some of whom may be living with dementia. On the day of our visit, there were 38 people living at the home.

At this inspection we found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in respect of sufficient staffing, safeguarding service users from abuse and improper treatment, meeting nutritional and hydration needs and good governance. You can see what action we told the provider to take at the back of the full version of this report
Staffing levels were not calculated in a way that ensured people's care needs were taken into account. The home did not currently employ enough staff to safely care for people. Not enough action had been taken to obtain temporary staff. The registered manager was not authorised to adjust staffing levels according to the needs of the people living in the home. Staff morale was low and they were tired.

Not all staff had received training on how to provide people with safe and effective care, which resulted in staff not recognising possible abuse or reporting it. Assessment of staff's competency had not been carried out to assess if their level of skill was adequate. Improvements were needed to ensure staff understood their role in recognising potential harm or abuse and in protecting people.

People received their medicines when they needed them, they were stored and managed safely.

Improvements were needed to ensure staff had regular supervision and support in order to reflect on their practice and develop their skills. Appropriate pre-employment checks had been carried out for new members of staff.

People were happy with the food provided and were able to make choices about what they wanted to eat. Where people were at risk of not eating or drinking enough, this was not always monitored regularly. Actions were not always taken to ensure that people had enough to eat and drink. The staff responsible for the monitoring of peoples intake of food and drink had not had their competency to do so assessed.

The registered manager ensured that people had access to appropriate healthcare. People were able to see a GP when they needed to and access support from community healthcare professionals.

People were involved in planning their care where appropriate, plans contained information about choice,

routines and interests to guide staff. Risks to people had been identified and assessed to reduce and mitigate potential harm. However, plans and records had not been reviewed or updated for some time, so were at risk of containing out of date or inaccurate information.

Staff were kind and friendly towards people living at the home, people responded warmly to staff and relationships were positive. Visitors were welcomed in to the home.

Activities were provided for people, although these were not advertised and people were not told about them in advance.

The governance systems in place were not effective at assessing and identifying improvements that were needed to the quality and safety of the care that was being provided. They had not been completed recently and information that was available did not provide an accurate view of the service.

Although the environment was well maintained, not all checks to prevent cross infection were completed, which put people at risk. The service did not check for the risk associated with legionella's disease, although had taken action to start doing this very soon.

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.

Not all staff were able to recognise or respond to signs of potential abuse and incidents had not been reported as required.

There were not always enough staff to meet all of the people's needs.

Identified risks to people had not been regularly reviewed and reassessed.

People were supported by staff to take their medicines safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not completed the necessary training they required to support people effectively.

Staff did not receive regular supervision and were not regularly assessed to ensure they were competent to perform their role.

People who were at risk of not eating or drinking enough were not monitored to ensure that they could remain healthy.

People were supported to see their GP and other community professionals.

Is the service caring?

Good

The service was caring.

Staff were respectful to people when providing people with care and support.

People's views about how they wanted their care to be provided were sought where appropriate.

Staff treated people kindly.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Assessments and care plans were completed but not regularly reviewed and the information contained within them was not up to date.

People and their relatives knew how to complain if they were not satisfied.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The current systems in place to monitor the quality and safety of the service were not effective.

Staffing shortages and the recruitment of staff had been poorly managed.

The registered manager was unable to conduct their management responsibilities

Docking 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.

The inspection visit was unannounced and was carried out on 14 and 16 November 2016 by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection the provider completed a Provider Information return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. We checked the information we held about the home. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us.

On the days we visited the home, we spoke with twelve people living at the home, four members of care staff, the registered manager and the provider's operations manager. We also spoke with relatives of four people living at the home. We looked at records relating to four peoples' care, which included daily records, risk assessments, medicine administration records, guidance from health professionals and mental capacity assessments. We also looked at quality assurance audits that were completed by the registered manager and the provider.

Requires Improvement

Is the service safe?

Our findings

Staff we spoke with told us that they had completed on line training in safeguarding people from abuse, but were not clear as to when they had last completed this. They were able to describe different types of abuse to us, and how they would look out for indicators of this, such as an injury to someone. We asked to look at the services training matrix so we could see documented evidence that staff had completed training in safeguarding people from abuse. The registered manager told us that not all staff were up to date with their safeguarding training and that this needed addressing urgently. This was because staff were required by the provider to complete this unpaid and in their own time. The registered manager told us that this meant that it was difficult to motivate staff to complete the training.

Staff told us that they would have no hesitation in reporting any concerns they had to the registered manager. However, some members of staff we spoke to told us that they would not consider reporting potentially abusive interactions between service users. They told us that this was because people living at the home were assessed as not having capacity as defined by the Mental Capacity Act 2005. This assumption by some staff was inaccurate, as all potential incidences of abuse should be reported to the local authority safeguarding team. The registered manager also has a statutory obligation to notify the Care Quality Commission (CQC) of any allegations of abuse. We concluded that not all staff had received sufficient recent training to ensure that they had enough knowledge of how to keep people safe from the risk of abuse.

We saw in one person's daily care records that they could sometimes become abusive towards other people living at the home. This was because the person was living with dementia, and could become frightened and distressed. We saw that these behaviours were identified and a detailed plan for staff to follow to reduce the impact of the behaviours had been written. This included potential triggers or situations that could lead to the person becoming distressed. However, we saw on multiple occasions that staff had not reported when the person had been abusive towards other people living in the home. These incidents had not been reported to the local authority safeguarding team, and statutory notifications to the CQC had not been submitted.

During our inspection we noted that a person living at the home had substantial bruising to one side of their face which was fading meaning it had not occurred recently. We asked the person about how this had happened, but they were unable to remember. A review of this person's care records showed that at no point had an entry been made that detailed the injury to the person. There was no information about the possible cause, that medical treatment had been sought or that the injury was monitored. We asked the registered manager to refer this to the local authority safeguarding team without delay as it was an unexplained injury that required further investigation. This meant that the registered manager did not take the appropriate action to make sure incidents were referred to outside agencies and investigated properly.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014

People living in the home had mixed views on the levels of staffing. One person told us, "If I need something there is always someone around to help me." Relatives we spoke with told us that they felt that there was

always someone to respond to any requests for help or support. However, one person said, "Sometimes I can't get help because the people here are so busy." Another person told us, "Sometimes they [staff] take a long time to come if you need help."

On the first day of our inspection, we arrived at 9am and saw that most people were out of bed and had received breakfast and personal care. Staff told us that people living in the home had been well that day and nobody had become distressed requiring additional support. However, the registered manager and all of the staff we spoke with told us that they felt that there were not enough staff employed to keep people safe, unless they worked a significant amount of over time. We asked the registered manager if they considered the home to be safe. They told us, "Potentially no, there are not enough staff and we can't keep these hours up. Staff are working 60 plus hours a week. We are falling behind on supervisions, training, care plan reviews and staff meetings." We reviewed the rota's of actual hours worked by staff during the previous month. We saw that for one week, of the fifteen staff members working, seven had worked in excess of 60 hours, and five had worked in excess of 50 hours. The registered manager told us that the recruitment of new staff had been difficult which led to a depletion of the size of the staff team.

We asked the registered manager how the staffing levels on each shift were calculated. They told us that the provider decided the staffing levels, and that as far as they were aware, no dependency tool was used to calculate this level. They also told us that levels were not adjusted or reviewed as the population of the home changed and people's individual needs varied. We saw that some people received 1:1 support at particular times of the day. This had been funded following an re-assessment of individual needs by the local authority. The rota's we reviewed showed us that this support had been provided.

Staff we spoke with all told us that they felt that there were not enough staff on duty to meet people's needs in a timely way. One staff member told us, "Not enough staff on shift, doesn't feel like there is enough staff particularly around times when people are distressed, it never changes." They also told us that people sometimes had to wait to receive their care, and some people had to wait until 10am to get out of bed, because there were not enough staff. They also told us that nearly half the people living at the home needed two staff to assist with personal care or moving and handling and four people required three staff to support them.

We concluded that there were times when there was not enough staff on duty to keep people safe. This was because there were not enough staff employed to ensure that sufficient staff were deployed at all times

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (reg 18-1)

People and their relatives told us that they felt safe living at Docking House. One person living at the home told us, "I feel very safe here and have no concerns." Another person told us, "I have been here for a year and I do feel safe and nothing worries me." A relative of a person living at the home said to us, "We consider our [relative] is very safe here and have no concerns."

Staff told us that they went through a thorough recruitment process when starting work at the home. They told us that they completed an application form, underwent an interview and were required to provide suitable references. Staff also told us that they were required to undergo a Disclosure and Barring Service (DBS) check. This enabled the registered manager to check that potential staff were safe to work at the service.

Risks to people had been assessed in detail. This included risks associated with moving and handling people, nutrition and hydration and supporting people whose behaviour may challenge. The registered

manager told us that because of staff shortages, some of these plans had not been updated recently. According to records we reviewed from the provider's electronic care records system, twelve people's risk assessments were overdue for review. Three people's assessments had not been updated for over 12 months and two had not been updated since May 2015. This meant that although risks to people had been assessed, not all of these had been reviewed to ensure that they were still current, and reflected any changes in need that the person had.

The premises and equipment were appropriately maintained to help keep people safe. A maintenance worker carried out routine maintenance. They also carried out health and safety checks on some equipment. The registered manager ensured that checks to the premises, such as for the fire detection system or for the servicing of equipment took place and provided us with records to confirm this. However, the registered manager told us that the home did not carry out checks to ensure that people living at the home were protected from the risks associated with legionnaire's disease. The provider's operations manager told us that the provider had recently purchased the testing equipment to enable them to do this, and that this would be starting to take place the following month.

We saw there were plans in place to respond to any emergencies that might arise and these were understood by staff. We saw that all people had a personal emergency evacuation plan, which detailed the assistance they would need in the event of an urgent evacuation of the building. However, these were only stored electronically, and would not be accessible to staff in an emergency. We brought this to the attention of the registered manager who told us that they would arrange for paper copies to be kept at exit points. The provider also had arrangements in place for ongoing maintenance and repairs to the building.

the inspection, we looked at how information in medication administration records and care notes for people living in the service supported the safe handling of their medicines. When we asked people and their relatives about their medicines, they told us that they received them on time. One person told us, "I get all my tablets on time and they always make sure I take them all." Medicines prescribed were stored safely for the protection of people who used the service and at correct temperatures. Supporting information was available to assist staff when giving medicines to individual people. There was personal identification information on each person's record to help ensure medicines were administered to the right person and information about how they preferred to take their medicines.

When people were prescribed medicines on an 'as and when required' (PRN) basis, staff had written information about when to give these medicines consistently and appropriately. Records showed that people living at the service were receiving their medicines as prescribed. Frequent internal audits were in place to enable staff to check records and monitor and account for medicines. These were overseen regularly by the provider's peripatetic manager, whose role included the safe management of medicines within the home.

Medicines were stored securely in a locked cupboard and there were appropriate processes in place to ensure medicines were ordered, administered, stored and disposed of safely. Staff authorised to handle and administer people their medicines had received training and had been assessed as competent to undertake medicine-related tasks.

Requires Improvement

Is the service effective?

Our findings

People and their relatives we spoke with told us that they felt staff knew how to support them well. One person told us, "The staff do know what they are doing and look after me very well. They always ask me if it's alright before they start. They are very polite. The food is very good and I get to see my doctor whenever I want."

Staff we spoke with told us that they undertook training in thirteen core subjects which were all delivered via e- learning. The registered manager told us that they set the pass mark for staff and had recently increased this to 85%. Staff who did not achieve this pass mark were required to recomplete the training and received support to do this from senior staff.

However, the registered manager told us that they were approximately four months behind with checking that staff had completed their training. We saw that there were significant gaps in the service's training records. This meant that we were unable to see that gaps shown in records were as a result of training not being completed, or because the records had not been updated. It also meant that the registered manager did not know which staff had the up to date skills and knowledge required in order to perform their role.

In the records we saw, we could see that seven staff had gaps in their training records. These staff had between four and nine of the 13 modules of training uncompleted. We could not see that all staff had completed or updated the training deemed necessary to support people effectively.
Staff told us the competency checks of their practice following completion of training did not take place. General observations of their practice did not occur either. When we spoke to the registered manager about this, they confirmed that these checks had not been taking place.

Staff told us that they had not received supervision or appraisals for some time. Supervision and appraisal of staff performance is an important way of ensuring that staff receive the development and support that they need to do their jobs well. They told us that this made them feel unsupported. One staff member told us they had no more than three or four supervisions in the more than four years they had worked at the service. Records we reviewed showed that fourteen staff were overdue to receive a supervision meeting. The records showed that these were overdue between three weeks and seven months. Six of which were over seven weeks, and three of which were over fourteen weeks. This meant that staff did not receive regular support and supervision in order to enable them to carry out the duties the are employed to perform.

Staff we spoke with told us that team meetings were infrequent and were usually only called following a complaint being made. We saw records that showed that staff meetings usually took place four times per year. The registered manager told us that some meetings had not taken place as usual recently.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (18.2)

We saw that a number of people living at the home were at risk of not eating or drinking enough in order that they stay healthy. People's care records identified where they were at risk, and what staff need to do to

reduce this. This included setting target amounts for people to eat and drink, and regular weighing so that any weight loss could be identified. We saw that for some people, daily records were kept so that everything that they ate or drank that day could be recorded. At the end of each day this was to be reviewed by one of the home's three nutritionists.

However, we saw that these records were not always filled in. We also saw that the results recorded on the person's paper based record, differed from the electronic records that these were uploaded on to. This was concerning because the electronic records generated the data and graphs that the nutritionists and healthcare professionals, such as a person GP, would review. For example, for one person we saw that on two days that week no entries had been made on their fluid intake log, and on one day that week, only one entry had been made. This entry showed that the person had only had 200mls of fluid to drink that day. A target amount of fluid to drink had not been set for that person. The electronic care log showed that the person had an additional 200mls of fluid later that day. Their fluid intake log on those three days had not been reviewed by a nutritionist.

We also noted that during the last three weeks, on four occasions, staff had not logged what the person had to eat on that day. We could see from the electronic record that this person's weight was declining, and they had gone from being 'underweight' to 'severely underweight'. We could not see from the record that this had been reviewed by the nutritionist or that the person had been referred to their GP. We brought this to the attention of the registered manager who agreed to take action regarding this straight away. We were concerned that not all people living at the home were receiving enough to eat and drink.

We asked the registered manager about the role of the nutritionist in the home. The registered manager told us that they were unsure about this role, as it had been created by the provider. They told us the staff were support workers who had undertaken additional training to be a nutritionist. However, training certificates were for an online course that did not provide an accredited professional qualification, so that staff were registered to provide nutritional advice. Nor had they been assessed as competent following the completion of this e-learning. We could not therefore be assured that they were appropriately qualified and competent to perform this role within the home. We also noted that on both days of our inspection, none of the three people in this role were on duty. This meant that the services own procedure of reviewing the intake of those people deemed to be at risk each day, was not always followed.

This is a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2014

We looked at how staff supported people with eating and drinking. People told us they enjoyed the food and were given a choice of meals and drinks. One person said, They always bring food and drink round during the day. I think the food is good here and I always get a choice off the menu." Another person commented, "The meals are alright and if I don't like something then they will get me something else. They are always bringing drinks, biscuits and fruit round during the day." We observed that refreshments and snacks were offered throughout the day. These consisted of hot and cold drinks and a variety of cakes and biscuits.

Weekly menus were planned and rotated every four weeks. The daily menu was displayed on a board in the dining area. People could choose where they wished to eat; some ate in their rooms, others in the dining areas or lounges. We observed lunch and saw that the dining tables were set. Staff interacted with people throughout the meal and we saw them supporting people sensitively.

The Mental Capacity Act (MCA) 2005 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 2005. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA 2005, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff confirmed they asked for people's consent before providing care, explaining the reasons behind this and giving people enough time to think about their decision before taking action. We observed staff spoke with people and gained their consent before providing support or assistance. The registered manager understood when an application for a DoLS authorisation should be made and how to submit one. This ensured that people were not unlawfully restricted

The registered manager had a good knowledge of the principles of the Act. They understood the importance of assessing whether a person had capacity to make a specific decision as well as the process they would follow if the person lacked capacity to make decisions. Care staff we spoke with had limited understanding of the principles of the Act, but told us that they had undertaken training in this area. They were able to explain to us the basic processes that took place when assessing a person's capacity. We saw that best interests meetings has been arranged in some cases. This was to ensure that any decisions made about a person's care, was done so by the appropriate people, and reflected the person's wishes. We did note however, that on occasions the recorded detail about these decisions was limited. We spoke to the registered manager about this and they agreed to review these documents.

People using the service and their relatives confirmed that health care from health professionals, such as the GP or dentist could be accessed as and when required. Records we saw showed people were registered with a GP and received care and support from other professionals, such as the chiropodist and the district nursing team.

Good

Is the service caring?

Our findings

People and their relatives told us that staff treated them with respect and kindness. One person said, "The care I get is good, the staff are polite, they always use my first name which I really like." Another person commented, "In the main the care is good and the staff are respectful. The staff here are very caring, and always go out of their way to help me. They are all so polite and respectful. They always keep an eye on you and if they think you need something, then they will always ask." Relatives gave us positive feedback about the staff team. One relative said, "The care my [relative] gets is very good. They go to a lot of trouble to make sure they are happy. One carer spent time with him showing photographs of the town where he used to live. It was really good for him as he remembers quite a lot." Relatives we spoke with said they were made to feel welcome in the home.

We observed that staff interacted in a caring and respectful manner with people living in the home. For example, support offered at meal times was carried out discreetly and at a pace that suited each person. Staff also acted appropriately to maintain people's privacy when discussing confidential matters or supporting people with personal care. We observed appropriate humour and warmth from staff towards people using the service. People appeared comfortable in the company of staff and had developed positive relationships with them. The overall atmosphere in the home appeared calm, friendly, warm and welcoming.

Staff understood their role in providing people with compassionate care and support. One member of staff told us, "I like working at Docking House, and I enjoy supporting people living with dementia, I always think, if I can make the residents smile, I am doing my job." There was a 'keyworker' system in place. This linked people living in the home to a named staff member who had responsibilities for overseeing aspects of their care and support.

We saw instances of people's independence being valued and upheld. For example, helping a person to choose to make a drink from the refreshments trolley. Staff spoken with gave examples of how they promoted people's independence and choices, such as supporting and encouraging people to maintain and build their mobility. One relative told us that staff had gone the 'extra mile' in supporting their family member to improve their mobility following a fracture sustained in a fall. One person told us, "The staff care for me well, and I feel comfortable with them, they all try to keep me doing things. People said they made choices throughout the day regarding the time they got up, went to bed, whether they stayed in their rooms, where they ate and what they ate.

The staff were knowledgeable about people's individual needs, backgrounds and personalities and were familiar with the content of people's care records. Where people wanted to and were able, they were involved in the planning of their care. One person told us, "They [staff] give me a chance to tell them what I like and what I don't like to do or how I would like to be looked after." Most people we spoke with told us that they were happy to leave these arrangements to family members and staff working at the service. However, they felt that staff knew what they wanted and needed, and that this was provided. The process of reviewing support plans helped people to express their views and be involved in decisions about their care.

People were also able to express their views by means of daily conversations, consultation exercises, residents' meetings and satisfaction surveys.

The registered manager and staff were considerate of people's feelings and welfare. The staff we observed and spoke with knew people well. They understood the way people communicated and this helped them to meet people's individual needs. People told us that staff were available to talk to and they felt that staff were interested in their well-being. People told us they were happy with their bedrooms, which they were able to personalise with their own belongings and possessions. This helped to ensure and promote a sense of comfort and familiarity.

Some people chose to spend time alone in their room and the staff respected this choice. We observed staff knocking on doors and waiting to enter during the inspection. There were policies and procedures for staff about caring for people in a dignified way. This helped to make sure staff understood how they should respect people's privacy, dignity and confidentiality in a care setting.

Requires Improvement

Is the service responsive?

Our findings

People made positive comments about the way staff responded to their needs and preferences. One person told us, "They certainly know what I like and enjoy. I have no complaints and have never had to complain. If I have a problem, I just talk to one of the carers." Another person we spoke with told us, "The [staff] here know what I like and what I don't like, and they know the things I like to talk about." Relatives felt staff were approachable and had a good understanding of people's individual needs. One relative said, "They do understand the little things that my [relative] likes." Another relative told us, "We certainly think that they know what she likes and doesn't like."

Staff identified and planned for people's specific needs through the care planning and review process. We saw people had individual support plans in place to ensure staff had the correct information to help them maintain their health, well-being and individual identity. Before people moved into the home, an initial assessment of their needs had been undertaken. We found the completed assessments covered all aspects of the person's needs. Wherever possible, people had been involved in their assessment of needs and information was gathered from relatives, and health and social care staff as appropriate. This process helped to ensure the person's needs were met within the home.

However, we saw that a number of people's support plans had not been recently reviewed. The registered manager told us that because of recent staff shortages, they along with senior staff had not been able to spend the time to review people's plans and update where required. The provider's electronic records system showed that eleven people's plans were overdue for review. The registered manager told us that usually support plans were reviewed on a monthly basis and if new areas of support were identified, or changes had occurred, then they were modified to address these changes. The registered manager told us that these plans would be reviewed within the following 4 weeks. The provider's operations manager told us that they were going to re-prioritise their own work load so that they would spend the majority of their time at Docking House. This was so that they could support the registered manager in reviewing the support plans.

We looked at three people's support plans and other associated documentation including relevant risk assessments. The plans were in sections according to people's needs contained details about people's life history and their likes and dislikes. The profile set out what was important to people and how staff should support them. The plans were sufficiently detailed to guide staff members care practice. Staff recorded the advice and input of other care professionals within the support plans so their guidance could be incorporated into care practice. Where possible, people had been consulted and involved in developing and reviewing their support plan.

The provider had systems in place to ensure they could respond to people's changing needs. For example, we saw the staff had a handover meeting at the start and end of each shift. During the meeting staff discussed people's well-being and any concerns they had. This made sure staff were kept well informed about the care of people living in the home. Daily reports provided evidence to show people had received care and support in line with their support plan. We noted the records were detailed and people's needs

were described in respectful and sensitive terms.

Staff had a good knowledge of people's needs and could clearly explain how they provided support that was important to each person. Staff were able to explain people's preferences, such as those relating to health and social care needs, personal preferences and leisure pastimes. This information was also contained within the persons support plan. People had access to various activities and told us there were things to do to occupy their time. We saw video clips of dancing sessions, Christmas parties, birthday parties and games afternoons that had been filmed so that relatives could see them. The home was visited by the provider's activity co-ordinator on one day each week. The registered manager told us that they did not know which day each week the co-ordinator visited, as this varied. We asked the registered manager if there was a plan or programme so that people knew what activities were available and when they would take place. The registered manager told us that activities were organised on an ad hoc basis. This meant that people did not know what activities they could partake in each day and could not plan for this. The registered manager told us that they would review this and consult with people living at the home.

We looked at how the service managed complaints. People told us they would feel confident talking to a member of staff or the registered manager if they had a concern or wished to raise a complaint. Relatives told us they would be happy to approach the staff or the registered manager in the event of a concern. Staff confirmed they knew what action to take should someone in their care want to make a complaint and were confident the registered manager would deal with any given situation in an appropriate manner.

The service had a policy and procedure for dealing with any complaints or concerns, which included the relevant time scales. We saw there were systems in place to investigate complaints. We saw records that indicated the matters had been investigated and resolved to the satisfaction of the complainant. This meant people could be confident in raising concerns and having these acknowledged and addressed.

Requires Improvement

Is the service well-led?

Our findings

On the first day of our inspection, the registered manager told us that a residents and families meeting had been arranged for the following day. They said that this was an urgent meeting because the local television news had broadcast a news item stating that the service was at risk of closure due to difficulties in recruiting staff. The registered manager also told us that they did not know that the television news crew had been invited by the provider to come and film in the home. They said that this had caused concerns amongst staff members and residents. The registered manager told us that many families of people living at the home were extremely concerned about this, as they had not been told previously. People and their relatives felt that there was a lack of openness and transparency regarding issues affecting the home from the provider.

Staff told us that currently morale amongst the team was very low. This was because the provider had been unable to recruit enough staff recently. Staff were regularly working additional hours in order to ensure that staff vacancies were covered. This had left them tired and frustrated but they did not want to let the registered manager or people living at the home down. They told us that if it hadn't been for the support from the registered manager then most staff would have left some time ago.

We spoke to the registered manager and the provider's operations manager about this. They told us that they were aware of the situation and were also concerned about the ability to recruit staff in the locality. They told us that they had placed adverts but that this had been unsuccessful. The registered manager told us that they had not been authorised to use an agency provider of temporary staff to supplement the staff team during this period by the provider. However, following the concerns raised by us on the first day of our inspection, when we returned on the second day, the registered manager told us that the provider had identified an agency for additional staff. The registered manager told us that they were expecting to interview potentially suitable staff from this agency provider in the coming days.

Staff also told us that they were concerned that the registered manager and senior support staff had not been able to complete other tasks in the service, such as updating records or the supervision of staff. This was because they had been working directly with people living at the service providing direct support. The registered manager told us that they regularly worked in the kitchen as the homes cook, and that the senior staff were working as cleaners. This was due to vacancies, annual leave and sickness. The registered manager confirmed this to be the case, during the week of our inspection, the registered manager was scheduled to be working in the kitchens for four days. We concluded that although there was an acute shortage of staff, the registered manager had been unable to effect the changes needed and the provider had not taken the necessary action to obtain additional staff.

Staff told us that they were unable to contribute to how the home was run. They said that meetings were for staff to be told things but that they didn't get to contribute. The registered manager told us that staff meetings had not taken place as usual recently because of the shortage of staff. On the days of our inspection, the registered manager was unable to locate minutes of previous meetings.

The registered manager told us that they had been unable to complete the provider's quality assurance

audits since July 2016. This was due to having to work directly with people living at the home to ensure that there was enough staff on duty, or because they were working in the homes kitchens. We saw that prior to July 2016, audits were conducted regularly and were in depth. An audit of people's care records had not taken place since July 2016, prior to this they were conducted every month. We saw noted in the audit completed by a senior support worker in July 2017 that, "All care plans had been updated in the last month." However, the electronic records system used by the provider showed that care plans had not all been updated. Records relating to safeguarding incidents and peoples nutrition and hydration were not always reviewed by senior staff. That meant that potential concerns were not always identified and action taken. We saw that some people's care plans had not been updated in the last 18 months.

The provider did not take enough action to ensure there were enough staff. This is turn resulted in records, training and systems to assess and monitor risks to people living at the home not being completed.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014

There was a registered manager in post at the time of our inspection. People living in the home and their relatives told us that they found her approachable and friendly. One person told us, "I like being here and am happy with everything. I can always talk to the staff and the manager. They are so friendly." A relative we spoke to told us, "The manager is very approachable and listens to what you say."

Staff spoke highly of the registered manager. One staff member told us, "[Registered manager] is really supportive." Another staff member told us, "The manager is good, they check that everything has been done, she is strict and takes action where needed." Staff understood and were confident about using the provider's whistleblowing procedure. There was a whistleblowing policy in place and staff were aware of it. Whistleblowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations. They can do this anonymously if they choose to.

A quality survey was conducted to gather feedback from people and their relatives. The feedback from these was very positive. We saw that respondents had all said that they had no cause for complaint. We saw comments such as, "Staff are very caring."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered persons did not take the appropriate action to make sure incidents were referred to outside agencies and investigated properly. Regulation 13 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Peoples nutritional and hydration needs were not always met. Action was not taken when a persons health was at risk from not eating or drinking enough. Regulation 18 (1) and (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems for monitoring and improving the quality and safety of the service, having regard to the accuracy of records and for acting upon the views of others, were not operating effectively. Regulation 17(1) and 17(2)(a),(b) and (c)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

There were insufficient, suitable staff properly deployed to meet people's needs safely.

Staff had not received the appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

Regulation 18(1) and 18(2)(a)