Eminence Care Service (Broomfield) Limited

Broomfield Residential Care

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Broomfield Residential Care is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The home is registered to accommodate 50 older people some living with dementia and mental health difficulties; at the time of our inspection, there were 30 people living in there.

At our last inspection in May 2017, this service was rated overall as good. We had received information that the service may have deteriorated and decided to undertake a Responsive inspection on 26 and 28 November 2018. At this inspection, we found that the service had deteriorated and has been rated as requires improvement. This is the third time the service has been rated as requires improvement in the last three years.

The first day of the inspection was unannounced.

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 2008 and associated Regulations about how the service is run.

There is not always sufficient staff deployed to provide care safely in a timely way. People are left waiting for assistance at times. There is limited opportunity for people to follow their interests or take part in meaningful activities which would keep them more active and mentally stimulated.

People's choices are limited and their preferences are not always considered. Their dignity is not always protected.

The systems in place to monitor the quality of care and effectiveness of the service are not always effective and fail to pick up some of the shortfalls in the quality and standard of care being delivered.

Staff undertake all relevant training but not all staff demonstrate their knowledge and understanding in practice.

Risk assessments are undertaken and plans put in place to mitigate the risk identified. However, the information recorded to mitigate the risk is not always sufficiently detailed to ensure people are cared for safely.

People receive care from staff that know them and are kind and compassionate. The staff are friendly, caring and passionate about the care and support they deliver. People have formed positive therapeutic

relationships with staff and are treated as individuals.

Staff understand the need to undertake specific assessments where people lack capacity to consent to their care and/or their day-to-day routines and staff support people in the least restrictive way possible; the policies and systems in place in the service support this practice.

Care plans are in place, which enable staff to provide consistent care and support in line with people's personal preferences and choices, however this need improving to ensure more detail is captured and kept up to date. End of life wishes are discussed and plans put in place when required.

People are cared for by staff who demonstrate an understanding of each person's needs. This is evident in the way staff speak to people and engage with them. Relatives speak positively about the care their relative receive and feel they can approach management and staff to discuss any issues or concerns they have.

Staff are appropriately recruited. People receive their prescribed medicines safely. Staff understand their responsibilities to keep people safe from any risk or harm and know how to respond if they have any concerns.

People's health care and nutritional needs are carefully considered and relevant health care professionals are appropriately involved in people's care. Family and friends are welcome at any time and encouraged to take part in any social events at the home.

People know how to raise a concern or make a complaint and there is an effective system in place to manage any complaints that may be received.
Broomfield is purpose built and there is development and refurbishment programme in place. We have recommended that the provider seeks advice as to the best design to make the home more dementia friendly.

At this inspection, we found the service to be in breach of two regulations of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. The actions we have taken are detailed at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There was not always sufficient staff deployed to provide the care and support people needed in a timely way.

Records to support the mitigation of risks were not always consistently completed leaving people at potential risk

There were safe systems in place for the administration of medicines and people could be assured they were cared for by staff who understood their responsibilities to keep them safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received training but did not always demonstrate their knowledge and understanding in practice.

People were involved in decisions about the way their support was delivered; staff understood their roles and responsibilities in relation to assessing people's capacity to make decisions about their care.

People had access to a healthy balanced diet and their health care needs were regularly monitored.

Is the service caring?

Requires Improvement

The service was not always caring.

People's preferences were not always considered and their dignity not always maintained.

The care given was task focussed with very little time outside delivering for staff to interact with people.

People were treated with kindness and positive relationships had developed between people and staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not always have sufficient detailed information for staff to provide meaningful activities for people.

People were confident that they could raise a concern about their care and there was information provided on how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The systems in place to monitor the quality of care were not effective to pick up shortfalls in record keeping and people's experience of daily life at Broomfield.

The registered manager and provider were visible and staff and people felt able to approach them with their concerns.

Broomfield Residential Care

Detailed findings

Background to this inspection

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

This inspection took place on 26 and 28 November 2018, the first day was unannounced. It was undertaken by one inspector, an assistant inspector 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 care service. In this instance, our expert-by-experience had cared for a relative.

We brought forward a planned inspection following concerns raised by an anonymous whistle-blower about staffing levels, poor care, unexplained bruising and the general cleanliness of the home. We looked at these concerns as part of our inspection.

Before the inspection we raised a safeguarding alert with the Local Authority in relation to the whistle-blower's concerns and spoke with the local safeguarding team and the commissioners of the service. Commissioners support people to find appropriate care and monitor the service.

We reviewed information that we held about the service such as notifications, which are events that happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies.

During our inspection, we spoke with eight people who lived in the home for their views about the services they received. We spoke with 11 members of staff, which included a team leader, two senior care assistants, three care assistants, a kitchen assistant, a house keeper, a laundry assistant and a maintenance person, plus the registered manager and the provider. We also spoke with two relatives, a family friend and two health care professionals who were visiting at the time of the inspection.

We observed care and support in communal areas including breakfast and lunch being served. Some people who lived at the service were not able to describe their views of what the service was like; we undertook

observations of care and support being given. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at the care records of four people to see whether they reflected the care given and three staff recruitment records. We looked at other information related to the running of and the quality of the service. This included quality assurance audits, training information for care staff, minutes of meetings with staff and arrangements for managing complaints.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection in May 2017 'safe' was rated as good. We found at this inspection, the service had deteriorated.

There was not always sufficient staff deployed to meet people's needs in a timely and holistic way. We observed that people were left sitting at the breakfast table for up to two hours following breakfast being served to them. People who needed assistance had to wait until staff were available.

The staff were stretched and had little time outside of delivering basic care to spend time with people. One person said," They (staff) have so much to do and are rushed: I have a lot of sympathy for them as there's not enough staff. I've been very down and I wish they had time to chat with me. It takes about 3-4 minutes to answer the call bell." Another person said," I only use the call bell in an emergency as I know they are busy. It must be soul destroying."

One family member commented," [Relative] is at risk of falls, there is an alarmed fall mat but they spend far too much time in bed and their walking is now restricted"

The home was divided into two separate areas, the extension area which catered for up to 34 people and the main building with 16 people. In the extension there were 22 people, 17 of which we were told by the senior carer required two staff to assist them. At the time of the inspection there were three care staff and one senior on duty plus an activities co-ordinator, who assisted with the breakfast, deployed in this area. The senior carer was responsible for administering medicines which left only three carers to support people whilst medicines were being administered. Many people were unable to express themselves which meant they were left waiting for assistance.

We saw that one person spilt their drink on themselves at 08:45am, although the staff were aware of this, the person was not assisted to change their trousers until 10:15 am. We saw that another person was brought in for breakfast at 08:55am and remained at the table until 10:30am, despite finishing their breakfast by 09:30am, they needed assistance to move away from the table.

In the main building there were eight people with one care staff and one senior care staff on duty. Three people required the assistance of two staff which meant that people were left unattended whilst they waited for staff to be available. The staff told us that this was not enough as they were trying to support people who had, at times, behaviours that could be challenging. We observed that throughout the day people's basic needs were met but there was a lack of stimulation for people and at times people were left unsupervised with no means of calling for assistance.

We observed that by lunchtime on the first day the registered manager had deployed more staff. The provider informed us that they did this as the registered manager normally assisted at mealtimes, but due to wishing to be available to the inspectors they had brought in one member of staff earlier to support. However, we received information following the inspection which suggested that it was not normal for so

many staff to be on duty and that at weekends there was not always many staff available.

These concerns constitute a breach of regulation 18: Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to the inspection, we had received information that the home was not always very clean and that people were potentially at risk of infection. On the day of the inspection we found the home generally clean. One person told us, "My room gets cleaned every day."

There were daily schedules and checklists in place which guided the housekeeping staff. However, we found that on occasions the checklists had been completed to say the work had been done and that this was not always the case. For example, the bathroom in the extension area, next to room 33 was checked at 8.45 am. The room had already been cleaned according to daily cleaning check list. The bath was not clean with dust and hair in it.

We observed that most staff wore protective clothing such as gloves and aprons when delivering personal care and serving food. However, we saw that the housekeeper only wore gloves and that in the bathrooms only latex gloves were available to use.

People who needed assistance with mobility and were hoisted did not have their own hoist sling. This meant that slings were shared and that put people at potential risk of infection.

The provider needed to ensure that there was a consistent approach taken to ensure that people were not put at unnecessary risk of infection.

People could not always be assured that they were being cared for safely. Assessments of risk had been undertaken, however, these were not always kept up to date and the information to support the mitigation of risk was not always completed with the detail required. For example, a person had been identified as having potential for poor skin integrity and required to be repositioned on a regular basis, although it had been documented that the person had been repositioned their exact position following a repositioning had not been recorded. This meant that staff did not know how often the person had lain in a position which put them at risk of developing a pressure ulcer.

We observed staff assisting someone to use a stand aide, the senior on duty advised the staff that this person required full hoisting now as their mobility had deteriorated. This information was not reflected in their care plan. We spoke to the team leader who advised that this person's mobility fluctuated and at times they were more able. This information needed to be clearly recorded and shared with staff to ensure that all staff fully understood the needs of the person.

Accidents and Incidents were recorded and the information was collated to enable the provider to analyse. We saw that action had been taken when the provider had identified a person had had several falls. The system could be further developed to enable the provider to analyse the information further to pick up trends.

The provider had ensured that environmental risk assessments were in place and there were effective systems in place to monitor the health and safety of people, which included regular fire tests and maintenance checks. However, the provider needed to ensure that regular fire drills where in place to ensure that staff fully understood what actions they needed to take in the event of a fire. Some staff were unsure as to what they were meant to do.

People were safeguarded against the risk of being cared for by unsuitable staff because there were appropriate recruitment practices in place. All staff had been checked for any criminal convictions before they started work at the home. However, the registered manager needed to ensure that when they were not able to secure previous employment references for people this was clearly documented and the risk assessed. This would mitigate any potential risk of people being cared for by people without knowledge of a full employment history.

People looked relaxed and comfortable in the presence of the staff. People told us they felt safe in the home. One person said, "I am always safe and I never feel threatened. Everyone is very welcoming and kind." Another person said, "It is a very caring home and I generally feel safe. There are a couple of staff who always seem to rush me and are a bit rough. I tell them I'm not a lump of meat and they stop immediately. I would certainly speak to the manager if I was that concerned."

Staff understood their roles and responsibilities in relation to keeping people safe and knew how to report concerns if they had any. We saw from staff training records that all the staff had undertaken training in safeguarding and that this was regularly refreshed. There was an up to date policy and procedure. The registered manager had contacted the local safeguarding team when any concerns had been raised and notified CQC as required.

At the time of the inspection the local authority was completing its investigation into the concerns we had raised with them. The registered manager and provider had fully cooperated with the investigating officer and had ensured any information they required was available.

Medicines were safely managed. There were regular audits in place and any shortfalls found were quickly addressed. We saw that people received their medicines at regular times and we observed people being given their medicines. Staff explained what the person was taking and ensured they had sufficient fluid to take them with; they stayed with the person and ensured that they had taken their medicines. Staff received training and their competencies were tested.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection in May 2017 'effective' was rated as good. We found at this inspection, the service had deteriorated and there were some areas for improvement.

People were supported and cared for by a staff team that had received the training and support they required to fulfil their roles but did not always demonstrate their knowledge and understanding of the training. For example, person-centred care, staff lacked the insight that by routinely getting people up for breakfast they were not considering people's individual preferences and choice. We observed that some staff were not confident in manual handling techniques.

We spoke to people about the staff training, one person said," I think the older experienced staff are excellent but some of the younger ones don't seem to understand that we need extra time to do things and can't be rushed." A relative said," The staff here are a bit mixed. I know they have training but every time we visit we have to ask where [relative's] hearing headphones are and why they are not on. The staff don't seem to be trained in the basics."

Staff said they felt they received plenty of training. One member of staff felt they could all benefit from more training around managing people's behaviour that can be challenging. We saw from staff training records that all staff had completed basic mandatory training such as health and safety, manual handling, safeguarding and infection control. Some training was refreshed each year and others within three years. Most of the training was eLearning with staff completing workbooks which were sent away and independently verified. The registered manager needed to ensure that all staff fully understood the training and could demonstrate that understanding in their practice.

The registered manager told us that he supported all new staff to undertake the care certificate as part of their induction. The care certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of all care staff in the health and social care sectors. It's made up of the 15 minimum standards that should be covered if you are 'new to care'.

There was a system in place to identify when staff were due to receive individual supervision and undertake annual appraisals. Care staff confirmed they received regular supervision from the registered manager and felt they had the opportunity to talk about any concerns and look at their own development. However, not all support staff received the same structured support and their supervisions were more adhoc or did not take place at all.

All staff would benefit from structured supervision to ensure that they have a full understanding of their roles and when concerns are raised such as around infection control there is an opportunity for both the staff member and registered manager to ensure their understanding and any training needs they may have.

People's care was effectively assessed to identify the support they required. Each person received a pre-assessment of their needs before they moved into the home which ensured that they moved in to the area of

the home which could best meet their individual needs.

The home liaised with other health professionals which ensured people's health care needs were met. GPs and District Nurses visited when needed. One person said, "I see the GP if I need them, the senior calls them for me." We saw from people's care records that when health professionals had visited this was recorded and any action required followed up. For example, a person had been referred to a dietitian when their weight loss had been identified. However, one family member told us that they did not always feel the staff acted promptly enough to seek advice and they had to chase things up.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes and hospitals is called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and we saw that they were. The registered manager and staff were aware of their responsibilities under the MCA and the DoLS Code of Practice. We saw that DoLS applications had been made for people who had restrictions made on their freedom and the management team were waiting for the formal assessments to take place by the appropriate professionals. Best interest decisions were recorded in care plans where people were unable to consent to their care, for example staff administering their medicines.

People told us that staff asked them what support they could give them. We heard people being asked at breakfast what they would like to eat and drink and if they were ready for their breakfast.

People were regularly assessed for their risk of not eating and drinking enough; staff used a tool to inform them of the level of risk which included monitoring people's weight. A daily record was kept for each person assessed at being at risk of not eating or drinking enough which demonstrated that staff monitored people's fluid and food intake. However, we found that not all records contained a target for the individual, the registered manager needed to ensure that targets were agreed and consistently recorded. If there were any concerns about people not getting enough nourishment this was discussed and referrals had been made to the dietitian for advice and guidance.

People were supported to eat a healthy balanced diet. There was a choice of meals available each day. We saw that at mealtimes people were shown the choice available to them to enable them to choose what they ate. If people did not like what was on offer they were offered an alternative.

People and their families had been involved in developing the menu on offer and taster sessions had been undertaken. The food was not prepared on-site and was bought in. There were systems in place to ensure that all food was cooked to the required temperature and that people were receiving a nutritionally balanced diet. People looked to have enjoyed their meal. One person said, "I had the chicken. I really enjoyed it."

People could choose whether they ate in one of the dining areas, lounge or in their own rooms. Staff were stretched at times trying to support people, but were attentive to people's needs. There was specialist equipment available to help people remain independent. The dining experience could be improved as there was very little opportunity for staff and people to interact. There were drinks and snacks available

throughout the day.

Broomfield is a purpose-built home which enabled people to access all areas. There was accessible garden space for people to use in good weather, and people had space for privacy when they wanted it. People had been encouraged to personalise their bedrooms; people had brought in personal items from their own home when they had moved in which had helped them in feeling settled in the home.

There were several people living with dementia in the home and the provider needed to look at ways to redesign and refurbish the home so that it was dementia friendly. The provider had plans in place to redesign the extension area of the home and this would be a good opportunity to enhance the environment so it is dementia friendly. We recommend the provider seeks guidance and advice on how to design a dementia friendly environment.

Requires Improvement

Is the service caring?

Our findings

At the previous inspection in May 2017 'caring' was rated as good. At this inspection, 'caring' has been rated as requires improvement as there were areas that had deteriorated and needed improving.

People were not always given the opportunity to express their preferences. We were informed by staff the night staff got people up before they finished their shift at 07:30 am. When we arrived at the home at 08:00 there were 14 people up and dressed in the extension area sitting waiting for breakfast, some asleep at the table. Only one person could tell us that they liked to get up early. They said," They get the night staff to do a lot of the washes in the morning to save time but it's too early. I mostly care for myself and I get up early but when I go down to the lounge at 06.30 there are a lot of people up and dressed for the day. It's not right as they sit for ages waiting for breakfast and fall asleep. I just wish they wouldn't get people up so early, I'm sure they deserve a choice."

We spoke to the registered manager and provider about this. The registered manager said as breakfast was served at 08:30 people needed to be assisted to get up. There was no information in peoples care plan to indicate what their preference was as to when they got up in the morning and there was no flexibility as to when people could eat their breakfast.

Care plans contained basic and limited information to inform staff of people's likes and dislikes, their preferences as to how they wished to be cared for, their cultural and spiritual needs. However, we found the information lacked detail for staff to follow. For example, in several care plans it stated the person liked to go to bed early, there was no specific time to guide staff. This meant that for those people who were not able to express themselves their care was based around staff routines and not people's individual preferences. We also saw in one care plan a person had expressed a wish for their bedroom door to be shut at night, however when we read the daily records it was recorded that the person's door was open the previous night. There was no record of whether the person had asked for their door to be left open that night.

People's dignity was not always respected. Those people who could tell us about how they were respected said that they generally felt their dignity was respected and protected. One person said, "The staff generally knock on my door, it's as good as any hospital, maybe better. There's mutual trust and respect." Another person said," They respect me, I like that." However, we observed someone being shaved in the lounge area where several people were sat. On another occasion eye drops were administered whilst someone was at the dining table with other people present. The staff lacked the insight as to how such actions failed to protect people's dignity.

We saw that people had developed positive relationships with staff and were treated with kindness. However, people's views of how they were cared for were mixed. One person said," The staff are brilliant, they are nearly all attentive and caring. It really is a care home; caring and very homely." Another person said," It's not perfect and some of the staff need to step up, but I have spoken to the manager and they are dealing with it." A relative said, "The care is a bit mixed, some staff seem to care and know [relative] well, others seem indifferent to them. We have discussed this with the senior staff and are keeping an eye on

things."

We observed some good interactions between the people and staff, although this tended to be task focussed. For example, a person with swollen legs looked very uncomfortable in their chair; a carer found a stool and gently raised their legs up and covered them with a blanket. They looked more relaxed afterwards. However, we saw that this person had been initially helped to sit in a chair by two other care staff who had not taken the time to ensure the person was comfortable before they left them.

We also saw that staff spoke quietly and discreetly to people to ask them if they needed any assistance. We observed that a carer spoke in the language of a person whose first language was not English. The person looked pleased and happy with the carer and you could see a genuine warmth between them.

There was a friendly and welcoming atmosphere around the home. Families and friends were welcomed at any time and encouraged to join in events at the home. One relative told us that they could visit when they wished.

People had access to an advocate to support their rights to have choice, control of their care and be as independent as possible. The staff understood when people might need additional support from an advocate and we saw in care records that people had been supported by an advocate. An advocate is an independent person who can help people to understand their rights and choices and assist them to speak up about the service they receive.

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection in May 2017 'responsive' was rated as good. At this inspection, 'responsive' has been rated as requires improvement as there were areas which had deteriorated.

People spent long periods of time with very little activity or mental stimulation offered to them. People told us that there were not many activities. One person said," The activities are basic, throwing a ball and things. I know it's difficult as many of the people don't know what's going on. I have seen a couple of external people come in to sing." The relatives we spoke to all said there were very limited or no meaningful activities people could take part in, but there was some entertainment brought in every so often. One relative said," Although [relative] goes for meals in the dining room, there aren't any activities that they do."

There was an activities co-ordinator who worked part time and some of their time was spent supporting mealtimes. The staff told us that if they had time they would sit and spend time with people in the afternoon. We saw there was a programme of activities displayed in the lounge area but staff told us that quite often what was on the programme did not happen.

On the first day of the inspection we saw a few people playing a game of skittles in the extension area but we saw no activities being undertaken with people in the main area. Some people sat watching the television and in the main area a film was being shown in the afternoon.

People's care plans lacked details around people's history, interests and hobbies. This meant that staff, especially those staff who covered for the activities co-ordinator when they were not on duty,did not always have the information they needed to engage in meaningful conversations and activities with people. The provider and registered manager needed to review how people spent their day and look at how they could ensure people had the mental stimulation they needed to support their well-being.

The care plans were reviewed regularly but there was little information to indicate whether there had been any changes in people's needs or as staff gained more knowledge of people what further information would assist staff new to the service to respond to people more effectively. Those staff who had worked at the service for several years demonstrated their knowledge and understanding of people but there was a need to ensure that information was shared.

People could not tell us whether they had been involved in developing their care plan and it was not clear from the records we saw how much people had been involved. One person said, "I feel involved in some things but not others. I never want to go to bed too early and that seems ok, but other things I don't get much choice. I go to the dining room if I feel like it, they have to help me. I don't think I've seen any paperwork about me, I expect it's all on computer." Relatives told us that they had been initially involved. One relative commented that at times they felt they had to chase up on things for their relative and that the staff were not always knowledgeable as to what was happening.

There were systems in place to ensure complaints were managed appropriately. We saw that complaints

were recorded along with the outcome of the investigation and the actions taken. People told us that if they had a complaint they would speak to one of the senior carers or the registered manager. One person said, "I haven't complained, but I would talk to the person concerned who I thought could help and take it upwards if nothing happened. I wouldn't put up with something I felt concerned about."

No end of life care was currently being delivered at the service. However, systems were in place should anybody require this care.

The service looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016 making it a legal requirement for all providers of NHS and publicly funded care to ensure people with a disability or sensory loss can access and understand information they are given. For example, information could be accessed electronically and in large print if required.

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection in May 2017 'well-led' was rated as good. At this inspection, 'well-led' has been rated as requires improvement as we found that there were areas that had deteriorated and not maintained.

The provider had systems in place to monitor the quality of the service and there were audits in place to check whether procedures were followed and standards maintained. However, these systems had failed to pick up that information in care plans was not always up to date and that records to support mitigating risks were not consistently being completed leaving people at potential risk.

People's experience of living at Broomfield had not been captured. This would have identified that there was not always sufficient staff effectively deployed to support people in a timely way. It would also have picked up that people were not getting enough mental and physical stimulation and that more meaningful activities needed to be undertaken with people to enhance their well-being.

There were meetings with staff, however, some staff did not always feel they were able to raise concerns or make suggestions as to how the service could be improved. Staff did feel able to approach the registered manager and felt he listened to them but they did not always feel action was taken to address some of their concerns.

The local authority monitored the service and we were aware that action plans had been completed when areas for improvement had been identified. However, the service needed to maintain and sustain the improvements they had made.

These concerns constitute a breach of regulation 17: Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The atmosphere around the home was friendly and welcoming. There was a suggestion box in the reception area for people, families and staff to use. The provider told us there had only been one suggestion in the last 12 months. There were no meetings with people or their families, however, the provider had invited families to come join a tasting session as they developed and changed the menus and families were always invited to any social events they had.

The provider regularly spent time at the home. We saw that people and staff knew the provider and was happy to talk to them if they wanted to.

There were procedures in place, which supported the staff to provide consistent care and support. Staff demonstrated their knowledge and understanding around such things as whistleblowing, safeguarding, equalities, diversity and human rights.

The registered manager had undertaken 'My Home Life' training which the local authority had provided and continued to liaise with other registered managers in the area. This gave the registered manager the

opportunity to share learning experiences and stay up to date with current legislation and best practice.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the provider had displayed their rating at the service and on their website.

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 17 HSCA RA Regulations 2014 Good governance The systems in place to monitor the quality and standard of care were not effective and failed to identify the shortfalls in the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not always sufficient enough staff deployed to provide timely safe care.