Dorrington House

Dorrington House (Watton)

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This was an unannounced inspection carried out on 19 and 20 August 2015.

Dorrington House (Watton) provides accommodation for up to 52 people who need personal care. The service provides care for older people most of whom live with dementia. There were 44 people living in the service at the time of our inspection.

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

We last inspected Dorrington House (Watton) on 28 and 30 October 2014. At that inspection we found the registered persons were not meeting all the regulations that we assessed. This was because there were shortfalls in the way medicines were stored and dispensed. After the inspection the registered persons told us that these shortfalls had been addressed. At this inspection we

Summary of findings

reviewed what steps the registered persons had taken to put things right and we found that the breach had been addressed. However, we noted that further improvements still needed to be made to the way in which medicines were managed.

At this inspection we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were not enough staff on duty to enable people to promptly receive all of the care they needed. In addition, the arrangements made to support people to eat and drink enough were not robust. Another problem involved people not being offered the opportunity to pursue their hobbies and interests. These shortfalls had not been identified and resolved because quality checks had not been rigorous and effective. You can see what action we told the registered persons to take in relation to each of these breaches of the regulations at the back of the full version of this report.

Staff (care workers) knew how to recognise and report any concerns so that people were kept safe from harm. People were helped to avoid having accidents and background checks had been completed before new staff were appointed.

Staff had not received all of the training and guidance they needed to assist people in the right way. Although people had benefited from seeing a range of healthcare professionals, the service had not always provided people with the support they needed to keep their skin healthy. Staff had ensured that people's rights were respected by helping them to make decisions for themselves. The Care Quality Commission is required by law to monitor how registered persons apply the Deprivation of Liberty Safeguards under the Mental Capacity Act 2005 and to report on what we find. The safeguards protect people where they are not able to make decisions for themselves and it is necessary to deprive them of their liberty in order to keep them safe. In relation to this, the registered persons had asked the local authority to review most of the people living in the service to ensure that their rights were being protected.

People were treated with kindness, compassion and respect. Staff recognised people's right to privacy, respected confidential information and promoted people's dignity.

People had received a wide range of practical assistance including people who had special communication needs and were at risk of becoming distressed. People had been consulted about the care they wanted to receive and they were being supported to celebrate their diversity. There was a system for resolving complaints.

People had not been effectively consulted about the development of the service and they had not benefited from staff receiving good practice guidance. The service was run in an open and inclusive way that encouraged staff to raise any concerns they had.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not consistently safe.

There were not enough staff on duty to promptly give people the care they needed.

Some of the arrangements used to manage medicines were not robust.

People had not consistently received all of the care they needed to keep their skin healthy.

People had been helped to avoid having accidents and from acquiring infections.

Staff knew how to recognise and report any concerns in order to keep people safe from harm.

Background checks had been completed before new staff were employed.

Is the service effective?

Requires improvement

The service was not consistently effective.

People were not reliably helped to eat and drink enough to stay well.

Staff had not received all of the training, guidance and support they needed to fully develop their ability to care for people.

Staff had liaised with healthcare professionals to help to ensure that people received the medical attention they needed.

People were helped to make decisions for themselves. When this was not possible legal safeguards were followed to ensure that decisions were made in their best interests.

Is the service caring?

Good

The service was caring.

Staff were caring, kind and compassionate.

Staff recognised people's right to privacy and promoted their dignity.

Confidential information was kept private.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People had not been fully supported to pursue their hobbies and interests.

People had not been fully supported to plan and review their care because key written information was not accessible to them.

Summary of findings

Staff had provided people with all the practical care they needed including people who lived with dementia and who had special communication needs.

People had been supported to fulfil their spiritual needs.

There was a system to resolve complaints.

Is the service well-led?

Requires improvement

The service was not consistently well-led.

Quality checks had not robustly identified problems that needed to be addressed.

People had not been effectively asked for their opinions of the service so that their views could be taken into account.

Staff had not benefited from receiving nationally recognised good practice guidance.

There was a registered manager and staff had been supported to develop good team work.

Dorrington House (Watton)

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 registered persons were 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.

Before our inspection we reviewed the information we held about the service. We reviewed notifications of incidents that the registered persons had sent us since the last inspection. In addition, we received information from local commissioners of the service and representatives of the local primary healthcare team who supported some people who lived in the service. This enabled us to obtain their views about how well the service was meeting people's needs.

We visited the service on 19 and 20 August 2015. The inspection was unannounced. The inspection team consisted of an inspector, a special professional advisor and an expert by experience**.** The specialist professional advisor had a detailed knowledge of best practice in relation to helping people to keep their skin healthy. We arranged for them to contribute to the inspection because we had received concerns about this aspect of the care that was being provided in the service. An expert by experience is a person who has personal experience of using services or caring for someone who requires this type of service.

During the inspection we spoke with 16 people who lived in the service and with six relatives. We also spoke with three senior care workers, eight care workers, the laundry manager and the registered manager. In addition, we spoke with one of the registered persons who was a member of the partnership that owned the service. We observed care in communal areas and looked at the care records for 10 people. In addition, we looked at records that related to how the service was managed including staffing, training and health and safety.

We 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.

After the inspection, we spoke by telephone with a further three relatives and three staff.

Requires improvement

Is the service safe?

Our findings

Our inspection on 28 and 30 October 2014 found that the registered persons had not consistently safeguarded people from the risks associated with the unsafe use of medicines. This was because medicines were not always stored at the correct temperature. In addition to this, medicines were not always stored securely to ensure that people only used them when it was safe to do so. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 that corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection the registered persons told us that more robust systems had been introduced to ensure that medicines were stored in the correct way so they were secure and kept at the right temperature.

This inspection found that medicines were being stored in the right way in that they were securely held in temperature controlled conditions. This meant that the registered persons were no longer in breach of the regulation.

However, we noted that further improvements still needed to be made. We looked at the medication administration records for some people living in the service. We found that there were gaps in the records which meant we could not be assured that people had received their medicines as intended by their doctor. Although quality audits had been completed they had not always identified these omissions. This situation had resulted in effective action not being quickly taken to put things right. There was also an increased the risk that people would not consistently benefit from using all of the medicines that a doctor said they needed to take.

The registered persons had established how many staff were needed to meet the care needs of the people living in the service. However, records showed that this level of staff cover had only been achieved for 15 of the 36 shifts immediately preceding the date our inspection. This was because the registered persons had not made effective arrangements to ensure that there were always enough staff on duty. Most of the staff we spoke with said that there were not always enough care workers on duty to meet people's care needs and that this was especially the case during weekends, in the afternoons and at tea time. Most of the people who lived in the service and who commented on this matter said that the service was not adequately staffed. One person said, "The staff are really busy and it's simply that they don't have enough people to do what needs to be done."

On both of the days of our inspection the service was understaffed because a vacant care worker's shift had not been filled. We witnessed six occasions on which people used the call bell in their bedrooms to request assistance. On four of these occasions they did not receive prompt assistance and had to wait between 10 minutes to 20 minutes. In addition, during a period of 30 minutes in the lounge, we saw one person ask for assistance from staff because they wanted to use the bathroom. We noted that they had to wait 10 minutes for a response. A person said, "When you ring for assistance you just have to accept that there'll be a delay in getting help. The staff are just too busy, they only have one pair of hands and can't do two things at once." Another person said, "I have waited 30 minutes for my bell to be answered. There's an emergency one which I have used when desperate". A relative said, "You can wait 15 minutes for the buzzer to be answered. This is not acceptable".

Shortfalls in how the registered persons met the minimum staffing level they had set had resulted in people not promptly receiving the care they needed and wanted to receive.

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

Staff had not consistently identified possible risks to each person's safety so that action could be taken to promote their wellbeing. This was because some of the arrangements to support people to keep their skin healthy were not robust. We noted that people who were at risk of developing pressure ulcers were not consistently supported to reduce the pressure on their skin in key places. This was because pressure relieving cushions were not always being used in the right way. In addition, staff were not consistently helping people to reposition themselves when seated in order to relieve pressure on their skin in the manner requested by healthcare professionals. A further problem involved the registered persons not having a robust system to ensure that all mattresses remained in a good condition. For example, we

Requires improvement

Is the service safe?

noted that one mattress had become worn at the edges and so did not provide a consistently soft surface. These shortfalls had increased the risk that people would not be able to keep their skin healthy.

Staff had taken action to reduce the risk of people having accidents. For example, people had been provided with equipment to help prevent them having falls. This included people benefiting from using walking frames, raised toilet seats and bannister rails. Some people had rails fitted to the side of their bed so that they could be comfortable and not have to worry about rolling out of bed. Each person had a personal emergency evacuation plan to ensure that staff knew how best to assist them should they need to quickly leave the building.

Records showed that when accidents or near misses had occurred they had been analysed and steps had been taken to help prevent them from happening again. For example, when a person had fallen the registered manager had arranged for staff to carefully observe the person to make sure they were being helped in the right way.

People said that they felt safe living in the service. A person said, “The staff are okay with me, I don’t have any problems with them.” Relatives were reassured that their family members were safe in the service. One of them said, “I live some distance from the service and I’m reassured that my family member is safe and treated with genuine kindness.”

Records showed that staff had received guidance in how to keep people safe. We found that staff knew how to recognise and report abuse so that they could take action if they were concerned that a person was at risk of harm. This action included contacting external agencies such as the Care Quality Commission, the local authority and the police.

We found that the recruitment and selection procedure helped to ensure that new staff were suitable to be employed in the service. Records showed that background checks had been completed for staff before they were appointed. These checks included obtaining a disclosure from the Disclosure and Barring Service to show that applicants did not have criminal convictions and had not been guilty of professional misconduct. In addition, other checks had been completed including obtaining references from previous employers. These measures all helped to keep people safe by ensuring that only suitable people were employed.

Some people who lived in the service and relatives said that the service was not sufficiently clean and so did not protect people from the risk of acquiring infections. One of these relatives said, “The cleaning is appalling. Rooms are not cleaned every day. In one case the carpet was not cleaned for three days and the toilet was left with excreta on the seat. The main reason is that they are just short of staff”. However, at the time of our visits we found the service to be clean and hygienic. In addition, staff were correctly using personal protective equipment such as disposable gloves when assisting people with close personal care. These measures helped to ensure that people were not put at risk of acquiring infections.

Requires improvement

Is the service effective?

Our findings

Some of the arrangements used to support four people who were at risk of not having enough nutrition and hydration were not robust. Three of the people had been offered the opportunity to have their body weight monitored. However, this had not been done for a fourth person who had been significantly underweight when the last check had been completed. In addition, this person had been prescribed special high calorie supplements to help increase their weight. The service had not received a supply of the supplements and the registered manager had not made any enquiries in relation to the matter.

The registered persons had concluded that staff needed to keep a record of how much each of the four people had eaten and drunk each day. This was necessary so that advice could quickly be sought from healthcare professionals if the amounts were not sufficient to promote their good health. However, the arrangements were not robust. This was because staff had not correctly recorded how much any of the people had eaten and drunk each day. Some meals and drinks had not been recorded at all and others had been recorded inadequately so it was not clear how much food and drink had been consumed. In addition, staff had not been given clear guidance and they were not sure how much the people in question should eat and drink each day to maintain their good health. We saw that no action had been taken even though the amount people had drunk had varied widely between days and was often below what the registered manager considered to be necessary.

Although other care records for the people concerned did not indicate they had experienced any direct harm, the oversights increased the risk of them not eating and drinking enough to promote their good health.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who were at risk of choking were being provided with the assistance they needed. This included having their food specially prepared and their drinks thickened so that they were easier to swallow. In addition, staff were correctly giving some people individual assistance so they could eat and drink safely and in comfort.

The registered persons said that staff needed to receive guidance and support in order to be able to care for people in the right way. However, these arrangements were not robust. This was because staff had not regularly met with a senior colleague to review their work and to plan for their professional development. New staff had not always received the introductory training that was intended for them. In addition, there were shortfalls in some of the refresher training provided for established staff. For example, records showed and some staff confirmed that suitable training had not been provided in relation to supporting people to eat and drink enough and in promoting their ability to keep their skin healthy. This situation had contributed to the shortfalls we noted in the competencies that some staff brought to their work. For example, some staff were not confident that they could recognise the signs when someone was becoming dehydrated or knew when to correctly use creams to promote people's ability to keep their skin healthy.

Even when training had been provided we found that staff had not always acquired the knowledge and skills they needed. For example, we noted that staff had received training in how to support people to pursue their hobbies and interests and yet remained uncertain about how to engage the interests of people who lived with dementia. These shortfalls in providing guidance and training for staff increased the risk that people would not consistently receive all of the care they needed.

People who lived in the service said and records confirmed that they received the support they required to see their doctor. In addition, staff had received assistance and guidance from district nurses who were calling regularly to the service to care for people who had medical conditions such as pressure ulcers. This meant that people's health could be quickly assessed and treatments provided. A relative said, "I know that the staff keep a watchful eye on my family member and call the doctor straight away because they always telephone me to let me know."

The registered manager knew about the Mental Capacity Act 2005. This law is intended to ensure that whenever possible staff support people who may lack capacity to make important decisions for themselves. These decisions include things such as managing finances and receiving medical treatment. We saw examples of staff having assisted people to make decisions for themselves. This included a person who liked to smoke cigarettes but who was not able to do so safely on their own. We noted that staff had discussed the matter with the person concerned

Requires improvement

Is the service effective?

and with their relative. This had enabled them to give their informed consent to staff storing the person's cigarettes and then assisting them to smoke in a safe way. A relative said, "I don't feel excluded at all from my family member's care. I like the way the senior staff ask for my opinion and advice. This is how it should be because I've known my family member for longer than anyone else."

When people lack the capacity to give their informed consent, the law requires registered persons and staff to ensure that important decisions are taken in their best interests. We noted that the registered persons had the necessary procedures in place to ensure that people's best interests were protected. These included consulting with relevant health and social care professionals in addition to relatives when a significant decision needed to be made.

In addition, the registered manager knew about the Deprivation of Liberty Safeguards. We noted that they had sought the necessary permissions from the local authority and so were only using lawful restrictions that protected people's rights.

Good

Is the service caring?

Our findings

Most of the people who lived in the service and their relatives were positive about the quality of care that was provided. A person said, "I get on very well with the staff who are kind and helpful." A relative said, "I've never had any concerns about the staff and I know that my family member would soon tell me if they weren't being cared for in the right way." However, a minority of people and relatives expressed reservations about the approach they experienced. A person said, "The staff do not have enough time to spend with you they seem focused on what they have to write down. As far as I am concerned most see me as part of a job rather than as a person". Another person said, "Some staff are lovely and that makes the day that bit nicer, but overall I feel as if I'm a number rather than a name".

During our inspection we saw that people were treated with respect and in a caring and kind way. Staff were friendly, patient and discreet when providing support to people. We saw that staff took the time to speak with people as they supported them. We observed a lot of positive interactions and noted how these supported people's wellbeing. For example, we saw a member of staff speaking with a person while they were assisting them to eat their lunch. This involved explaining what food was on their plate and asking them which portion they wanted to taste next.

We saw that staff were compassionate and supported people to retain parts of their lives that were important to them before they moved in. For example, we observed a member of staff supporting a person to reminisce about all of the countries they had visited when serving in the army during the second world war. Another example involved staff organising a small party to celebrate a couple's wedding anniversary. This had involved providing a cake, refreshments and entertainment.

Staff gave people the time they needed to express their wishes and respected their choices. For example, we saw that a person was looking for a favourite magazine when sitting in the lounge. A member of staff noticed this and suspected that the magazine had been left in the person's bedroom. After they had fetched it, the person concerned smiled broadly and was seen to quickly become engaged turning the pages.

There were arrangements in place to support someone if they could not easily express their wishes and did not have family or friends to assist them to make decisions about their care. These measures included the service having links to local advocacy groups who are independent of the service and who can support people to express their opinions and wishes.

Staff recognised the importance of not intruding into people's private space. People had their own bedrooms that were laid out as bed sitting areas. This meant that people could relax and enjoy their own company if they did not want to use the communal lounges. Staff had assisted two people who were related to each other to create their own private lounge. We noted that they had organised the room as they wanted and had used items of their own furniture.

Bathroom and toilet doors could be locked when the rooms were in use. Staff knocked on the doors to private areas before entering and ensured doors to bedrooms and toilets were closed when people were receiving personal care. A person said, "When I'm helped to have a bath the door is always closed so I'm not on show which I'd hate."

People could speak with relatives and meet with health and social care professionals in the privacy of their bedroom if they wanted to do so. A relative said, "When I go in to see my family member it's all very relaxed and we can use their bedroom for a quiet chat if we want."

Written records that contained private information were stored securely and computer records were password protected. Staff understood the importance of respecting confidential information. They only disclosed it to people such as health and social care professionals on a need to know basis. A person said, "The staff don't talk about other residents in front of me."

Requires improvement

Is the service responsive?

Our findings

Staff had not fully supported people to pursue their interests and hobbies. There was no one to coordinate and evaluate how well people were being supported to engage in activities. In practice, staff were expected to offer people opportunities to pursue their hobbies and interests as and when they had the time.

Staff did not follow a clear plan to explain to people what activities were available each day. Apart from a gentle exercise class each week, records showed that on other days most people had not been supported in any real sense to be engaged in social activities that interested them. During our inspection visit we only saw three small scale social activities taking place in the lounges that in total involved five people. We noted that most people spent time on their own. Although some people read their newspapers and watched television other people sat in their armchairs without anything in particular to do. A person said, "When I first arrived they seemed keen to know what I liked doing and what I was interested in, but since then I've never been asked". Another person said "There are definitely not enough things going on."

During our SOFI observation we noted the number and nature of the contacts that were experienced over 40 minutes by three people who were sitting in the main lounge. We saw that for nearly all of the time they did not have any contacts and were withdrawn. When we spoke with each of the people afterwards they responded positively, smiled and chatted. One of them shrugged their shoulders and said, "It is a long day in here with not much to do."

Although we saw one person being assisted by staff to go out to the local shops, records showed that most people had not been supported to leave the service to enjoy community resources. None of the staff could recall when people had last been supported to visit a place of interest. We noted that no visits had been planned and staff did not anticipate that any would take place. Staff said that people were not even supported to go into the service's garden because it was uninviting and difficult to access by people who had reduced mobility.

These shortfalls had resulted in people not being adequately supported to pursue their interests and hobbies.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had consulted with people about the care they wanted to receive and had recorded this process in a care plan for each person. Records confirmed that these care plans were regularly reviewed to make sure that they accurately reflected people's changing wishes. However, we noted that most of the information in the care plans was not presented in a user-friendly way to help people understand it. For example, there was little use of pictures and colour to bring information to life. This oversight reduced people's ability to review the way in which staff had recorded their wishes to make sure the information was accurate.

However, we saw a lot of practical examples of staff supporting people to make choices. For example, we saw that people were supported to use their bedroom whenever they wished to do so. In addition, we heard a member of staff supporting a person who wanted to change the original time they had chosen to be assisted to have a bath. This was necessary because their relative was due to call and the person was concerned that they might not be ready to greet them. We noted that the person concerned was pleased with the new time they had agreed with the member of staff. A person said, "I don't feel as if I have to fit in here. I can do what I like each day and I use my bedroom when I want."

People said that staff provided them with all of the practical everyday assistance they needed. This included support with a wide range of everyday tasks such as washing and dressing, using the bathroom and getting about safely. In addition, staff regularly checked on people during the night to make sure they were comfortable and safe in bed. A person said, "I want to be independent but there are some things I just can't manage now and the staff are there to help me with these things."

Staff knew how to relate to people who had special communication needs and who expressed themselves using short phrases, words and gestures. For example, we observed how a person pointed towards the door of the lounge in which they were sitting. A member of staff recognised that the person wanted to be assisted to use the bathroom. The person was then assisted to leave the lounge and was pleased to be helped to walk to a nearby bathroom.

Requires improvement

Is the service responsive?

In addition, staff were able to effectively support people who lived with dementia and who could become distressed. We saw that when a person became distressed, staff followed the guidance described in the person's care plan and reassured them. They noticed that a person was frowning and becoming upset without any obvious reason. The member of staff made reference to a picture in the magazine that the person was reading. By pointing towards someone's mouth they were able to establish that the person wanted to have a drink of water. Once they had been provided with a drink we saw the person smile and become reassured. The member of staff had known how to identify that the person required support and had provided the right assistance.

People said that they were provided with a choice of meals that reflected their preferences. We saw that people had a choice of dish at each meal time. In addition, records showed that the chef prepared alternative meals for people who asked for something different. We were present when people had lunch and noted the meal time to be a pleasant and relaxed occasion. Although some people considered that the menu was too repetitive most of the comments we received were positive. A relative said, "I've been there on a number of occasions when a meal has been served and I've been impressed with the quality of the food."

People were supported to express their individuality and to celebrate their diversity. People who wished to meet their spiritual needs were offered the opportunity to participate in a regular religious service. In addition, the registered manager was aware of how to support people who did not have English as their first language including being able to access translator services.

People and their relatives said that they would be confident speaking to the registered manager or a member of staff if they had any complaints about the service. A person said, "I've never had anything to complain about. When there are little niggles the staff are genuinely keen to put things right."

Each person who lived in the service had received a document that explained how they could make a complaint. The registered persons had a procedure that was intended to ensure that complaints could be resolved quickly and fairly. Records showed that the registered persons had not received any significant complaints since our last inspection.

Requires improvement

Is the service well-led?

Our findings

Although there were systems to assess the quality of the service they were not always effective. This was because quality checks completed by the registered persons had not consistently ensured that people were protected against some key risks to their wellbeing and safety. All of the problems we have described in this report had not been identified by the registered persons before our inspection. These included oversights in providing key elements of the care people needed to receive, ensuring enough staff cover, managing medicines safely and promoting people's ability to enjoy social activities. In addition to these issues, we found that the registered persons had not properly assessed the adequacy of the fire safety system. This oversight had contributed to some fire safety checks not being correctly completed to safeguard people from the risk of fire.

In addition to the checks completed by the registered manager, we noted that the registered persons said that it was necessary to have quality audits regularly completed by an independent consultant. However, this arrangement was not robust. This was because the audits were significantly overdue and no one could recall any information about the last audit including whether it had recommended that any improvements be made.

Shortfalls in the auditing process meant that the systems and processes in place were not operating effectively to ensure compliance with the regulations.

In addition, the registered persons had not provided the leadership necessary to enable staff to benefit from nationally recognised good practice guidance. For example, the service had not engaged with a number of initiatives that are designed to promote high standards of care for people who live with dementia or who need additional assistance to keep their skin healthy. This oversight had contributed to the shortfalls we identified including how people were supported to pursue their hobbies and interests and in the arrangements made to promote people's ability to keep their skin healthy.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Insufficient use of good practice guidance was also reflected in the arrangements that had been made to enable people to contribute to the development of the service. Although staff consulted with people informally about the day to day running of the service other arrangements were not robust. The registered manager said that there were regular meetings of a 'residents' forum'. These meetings were intended to provide an opportunity for people who lived in the service and their relatives to discuss how well the service was doing and to suggest improvements. However, records of the last meeting indicated that only five people who lived in the service attended. The registered manager said that the administrator complemented the meeting by speaking individually with people who had chosen not to attend. However, none of the people we asked about this matter could recall these conversations and there was no other evidence to indicate how well this exercise was being completed. Although there was a newsletter, there was no other system in use to enable relatives to be consulted about the development of the service. These shortfalls had reduced the registered persons' ability to consult with people so that their views could inform the future development of the service.

People who lived in the service and relatives said that they knew who the registered manager was and that they were helpful. During our inspection visit we saw the registered manager talking with people who lived in the service and with staff. They had a good knowledge of the care each person was receiving. They also knew about points of detail such as which members of staff were on duty on any particular day. This level of knowledge helped them to effectively manage the service and provide leadership for staff. A relative said, "I find the manager to be quiet but kind and helpful. You have to seek her out but when you do she's very reassuring."

There were arrangements to develop good team working practices to help ensure that people consistently received the care they needed. There was a named senior person in charge of each shift. During the evenings, nights and weekends there was always a senior manager on call if staff needed advice. There were handover meetings at the beginning and end of each shift so that staff could review each person's care. In addition, there were regular staff meetings at which staff could discuss their roles and suggest improvements to further develop effective team working. These measures contributed to supporting staff being able to care for people in a responsive and effective

Requires improvement

Is the service well-led?

way. A relative said, "I do think that the service is well run. I can see for myself that my family member is well cared for and has been so for all of the time they have lived in the service."

There was an open and inclusive approach to running the service. Staff were confident that they could speak to a senior colleague or to the registered manager if they had any concerns about another member of staff. They said that positive leadership from senior staff in the service reassured them that they would be listened to and that action would be taken if they raised any concerns about poor practice.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered persons had not deployed sufficient suitably qualified, competent, skilled and experienced staff to enable people to receive the care they needed.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The registered persons had not ensured that there were safe systems to meet people's nutritional and hydration needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The registered persons had not ensured that people were supported to promote their autonomy, independence and involvement.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered persons had not protected people who lived in the service against the risks of inappropriate or unsafe care by regularly assessing and monitoring the quality of the service provided.**