Nadam Care Ltd

Belamie Gables Care Home

Inspection report

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Ratings

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

Overall summary

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

We carried out this inspection on 7 November 2014. It was unannounced, which meant that people, staff and the provider were not aware we would be visiting.

Belamie Gables Care Home provides residential care for up to 20 older people without nursing needs, but with other care needs, including dementia care. At the time of our inspection 15 people were living in the home. The house consisted of two floors, with bedrooms and bathrooms on each floor, and a communal lounge on the ground floor. Stairs and a lift provided access between floors. People had access to a fenced garden. The front door was secured, and exits were alarmed, to alert staff should people leave the home when they were not aware of dangers that could affect their safety.

Summary of findings

A registered manager was not in post at the time of our inspection, but the person acting as manager had submitted an application to take up this 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.

At our previous inspection on 29 May 2014 the provider was not meeting the requirements of the law in relation to consent to care and treatment, the care and welfare of people, safeguarding people from abuse, and assessing and monitoring the quality of the service. Following the inspection the provider sent us an action plan stating they would make the required improvements by 31 July 2014. During this inspection we checked to see if these improvements had been made. We found that they had for some of the concerns identified, but not for all of them.

There were not sufficient staff to meet people's identified care needs at all times. One person requiring one to one support did not always receive this. Another person's behaviour was not effectively managed to meet their needs, or to reduce the impact of this on others.

People were supported by care staff who had completed required training to meet their basic care needs, such as mobilising safely. However, staff told us they did not always feel sufficiently skilled or confident to meet people's dementia care needs, and that not all training was effectively delivered to meet their learning needs.

People told us they felt safe with staff. Staff understood the signs of abuse, and the processes to notify and address incidents. However, we noted that one incident had not been identified as a risk of abuse, and therefore had not been notified to the safeguarding authority or the Care Quality Commission (CQC) as required until we requested that they do so.

Records did not always document people's current needs, preferences or wishes. They did not always document how people had been involved in or consented to their plan of care. Complaints records were not always kept confidentially.

People were supported by caring and kind staff. We observed staff engaging with people respectfully, providing reassurance and comfort when people were anxious. A range of activities were provided throughout the day, and people were encouraged and thanked for joining in meaningful activities, such as preparing tables for meals. Mealtimes were a social occasion, and staff ensured people's preferences and needs were met in the range of meal choice provided.

Risks affecting people's safety had been identified, and actions taken to reduce the risk of harm. As people's care needs changed, care plans and risk assessments were reviewed to ensure people's needs were met. Medicines were stored and disposed of safely. Staff had been trained and assessed to administer medicines safely.

People's comments were welcomed through surveys, residents meetings and direct conversation with the manager and provider. Relatives stated complaints had been satisfactorily resolved when raised. The office was open for people and relatives to meet with the provider and manager throughout the day if they wished.

Staff had opportunities to raise issues and request support through staff meetings and individual supervisory meetings. Action plans demonstrated progression to address issues identified through the manager's reviews of care and safety. Although most of the staff spoke positively about the manager, the manager's ability to develop and improve the home was limited by the amount of time they spent providing personal care to people, due to staff absence.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's needs and risks affecting their wellbeing had been identified, but staffing levels and skills were not always sufficient to meet these safely.

People's safety had not always been promoted through the correct notification of incidents to the appropriate authorities.

Medicines had been safely prescribed, stored, and disposed of. However, some people did not receive their medicines at the right time, which meant they may not effectively keep people safe from known health risks.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always have sufficient training, confidence or knowledge to support people's needs effectively.

People were mostly supported to maintain a balanced and healthy diet. Although staff knew people's dietary needs and preferences, staffing levels meant they were not always aware when people missed a meal.

People were supported to make choices and decisions. Where people did not have the mental capacity to make an informed decision, staff understood the legal process to follow, but did not always document this effectively.

Is the service caring?

Good

The service was caring.

People said staff were kind, gentle and patient. People carried out meaningful tasks within the home that made them feel valued.

People's dignity was promoted through the actions taken by staff. Staff were respectful and caring when speaking with people.

People were supported to voice their choices and preferences.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Although people or those important to them were involved in initial care planning, it was not always clear how they were involved in further decision-making about their care or treatment.

People joined in with activities provided in the home. However, there was little engagement with activities outside the home, and records did not demonstrate that people's preferred activities were met.

Summary of findings

People knew how to raise concerns with the provider, and felt comfortable to do so. However, information about these was not always stored confidentially.

Is the service well-led?

Requires Improvement

The service was not always well led.

People and their relatives felt complaints were addressed satisfactorily. However, information was not always stored confidentially.

The manager and provider were visible in the home. People and staff were able to approach them to raise concerns or seek advice. However, staff stated that although management listened to their concerns, they did not always act to resolve them.

Although the manager had systems in place to monitor the quality of the service, they were not able to drive improvements. They were often required to support people with their daily care needs rather than attend to managerial duties.

Belamie Gables Care Home

Detailed findings

Background to this inspection

The inspection took place on 7 November 2014 and was unannounced. The inspection team consisted of two inspectors and an inspection manager. Before the inspection we looked at previous inspection reports and notifications that we had received. A notification is information about important events which the provider is required to tell us about by law. We had not requested a Provider Information Review (PIR) for this inspection. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Concerns brought to our attention regarding poor care practices, including moving people safely, were used to inform our inspection. We contacted a local authority commissioner of the service prior to our inspection, and spoke with a district nurse following our inspection to obtain their feedback about the care provided in the home.

During our inspection we talked with 11 people who use the service, four people's relatives, the provider and the person managing the service. We also spoke with five care workers and the cook, during and after our inspection. Some people living in the home were unable to tell us about the care and support they received. We spent time observing the care and support these and other people received throughout the day, including activities, mealtime support and the administration of medicines, to inform our views of the home.

We 'pathway tracked' four people's care. This means we spoke with them and looked at their care plans, then observed the support they received and reviewed daily records, to ensure they received their planned care. We reviewed a total of seven people's care plans and four staff files. We looked at staff training plans and the working roster for October 2014, a selection of policies and procedures, and records relating to the management of the service. We viewed feedback gathered by the service from people, relatives, staff and health professionals, and considered how this and quality assurance audits were used to drive improvements in the service.

At our previous inspection on 29 May 2014 we had found the provider was not meeting the requirements of the law in relation to consent to care and treatment, care and welfare, safeguarding people and assessing and monitoring the quality of the service. We looked at these areas as part of our inspection, to check that the provider had taken action to reach compliance with the Health and Social Care Act 2008.

Inadequate

Is the service safe?

Our findings

At our inspection in May 2014, we found staff did not understand their responsibilities to keep people safe from harm. Potential abuse had not been reported to relevant agencies to ensure action could be taken to make people safe. The provider sent us an action plan outlining the improvements they would make. They said these would be in place by 31 July 2014.

At this inspection we found the provider had taken action to address these concerns but some improvements were still required. Although staff training had been updated, the provider's response to safeguarding concerns remained inconsistent. Some safeguarding incidents had been reported to the local authority and the Care Quality Commission (CQC), and investigated appropriately. However, one safeguarding incident had not been identified or reported by the provider. People told us that this incident had disturbed them and made them anxious. Although the manager had taken actions to reduce the risk of repetition, they had not recognised this incident as potential abuse. By not reporting this concern, action could not be taken by the relevant agencies to ensure people were safe. We asked the provider to ensure this incident was reported promptly, and they subsequently referred this to the local authority and CQC.

People had not been safeguarded against the risk of abuse as the manager had not identified the possibility of abuse. This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

One person told us "I feel comfortable with the carers, and trust them. They help me and make sure I don't fall". All the people we spoke with told us they felt safe in the home. One person had commented in written feedback to the provider 'Nobody should be frightened to come and live here. We are looked after very well'. People's safety was promoted by the use of alarms on exit doors. The front door was kept secured with a keypad. These measures alerted staff should people leave the home when they were not aware of dangers that could affect their safety. Staff told us they were aware of the provider's whistle blowing policy, and were prepared to use this if necessary.

A relative said staff were "stretched", and one person told us staff did not have time to chat anymore. We observed that people did not always receive the support they required promptly to keep them safe. One person was due to attend a hospital appointment, but staff were not available to help them into their wheelchair safely when they needed to leave. They were assisted by a relative, who told us they were not trained to move the person safely. This could have placed them and their relative at risk of injury.

Another person required one to one supervision at all times to keep them safe. Although a care worker was assigned daily to support this person, we observed that they struggled to provide them with individual support at all times whilst ensuring other people received their planned care. On one occasion the person had left the home unobserved and was wandering in the garden without appropriate wet weather clothing. We assisted them to come back into the home. At another time a care worker had to stop administering medicines to support this person. This meant there was a risk that the care worker would be distracted from administering medicines safely. This could potentially place people at risk of harm through errors made when supporting them to take their medicines.

The provider explained staffing had been increased at night to provide additional support for people, as it had been identified that people's care needs at night had increased, and now required additional staff support. However, care workers told us people's support needs had also increased during the day, and that they struggled to meet these increased needs. This could place people at risk of harm, as sufficient staff may not be available to meet their needs promptly, for example to provide continence care or to help them to transfer safely between wheelchairs and seats. Staff comments included "We don't have time to chat with people or relatives", and "There aren't enough staff to meet people's wishes, just their needs".

We saw staff were struggling to complete to all of their allocated tasks before the end of their shift. All shifts had been covered in accordance with the provider's requirements, but some staff had been asked to work for many consecutive days to cover staff absences, with few days off during October 2014. Care workers told us that they were often too busy to take regular breaks during the day. This meant that people's safety could potentially be adversely affected, as staff did not always get sufficient rest to ensure they could safely respond to people's needs.

Risks to people's safety had been identified by the provider. Although care records contained guidance to manage

Inadequate

Is the service safe?

these risks, staff were not always able to follow this guidance. We observed staff helped people when they required assistance to move safely. They had been trained to use moving and handling equipment safely by the occupational therapist. Staff ensured people did not feel rushed, in order to reduce the risk of falls. However, there was a risk that people may be at risk of harm at times, due to a lack of available trained staff to help them to move when they wanted. We observed a visitor reminded one person that it was unsafe to move when they wished, as this would have placed them at risk of falling. They had to wait a short time until a care worker was available to help them to move to attend to their personal needs.

The provider had not ensured there were sufficient numbers of staff available at all times to keep people safe. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

The provider's recruitment policy helped to ensure people were not placed at risk through the employment of inappropriate staff. Applicants demonstrated they were of suitable character through the completion of criminal record and proof of identity checks, and references provided by previous employers. New recruits completed an induction programme to ensure they were able to support people safely.

Accidents had been reported in accordance with the provider's policy. Regular checks had been completed to ensure safety measures were effective, such as inspections and tests of fire extinguishers and alarms. Contingency plans were in place to deal with emergencies such as severe weather, healthcare associated illnesses, and fire evacuation. These measures were in place to promote the safety of people, staff and visitors.

We observed people receiving medicines during the day. People received their medicines safely, although the care worker administering medicines did not have protected time to administer these. This could potentially mean that the care worker could be distracted from their task, and so place people at risk of medication errors. Medicines were stored securely, and administered by a trained member of staff. All staff responsible for administering medicines had received training to make sure they were equipped with the skills and knowledge to ensure people were protected from the risk of unsafe administration of medicines.

Staff were informed of people's allergies, and times for administering medicines were colour coded as a visual prompt for staff. Documentation ensured staff understood how, when and where to apply topical creams, and daily records demonstrated that staff followed this instruction. People were not always given their medication at the time it was required. For example, two people had been given medicines at mealtimes that had been prescribed to be given before food. Although this did not cause them harm, it meant that the medicines may not work effectively. When we informed the care worker of this, they told us they would amend medication times accordingly.

Requires Improvement

Is the service effective?

Our findings

Staff did not always have the necessary skills and knowledge to enable them to effectively meet all the needs of the people they supported. Care workers were trained in subjects including moving and handling people, and safeguarding people at risk, and records confirmed training was kept up to date. However, people with dementia and others affected by their behaviours were not always effectively supported due to some staff's lack of skills and knowledge in dementia care. For example, we observed one person's behaviour disturbed others in the lounge, which made people anxious. One person stated "It's been like this for days", and described how it affected their wellbeing and contentedness in the home. Staff told us they required training in dementia care, and how to support people to manage their behaviours. One care worker said "I've had some dementia training, but not a lot", and another told us "I need more information" on dementia awareness.

We looked in detail at one person's care plan, who was on a short stay in the home. The information contained in their care plan did not inform staff how to consistently respond to this person's behaviours. We observed that some staff did not understand how to provide this person with the care they required to support and manage their behaviour, or to reduce the impact of this for other people.

The provider had not ensured that staff had received appropriate training to enable them to support people's care needs effectively. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

Staff told us, and records confirmed, they attended individual supervisory meetings. These provided an opportunity to raise concerns and discuss aspirations. Senior staff had been trained to lead supervisory meetings.

At our inspection in May 2014, we found the provider did not always document people's consent to care, and had not acted in accordance with legal requirements where people lacked mental capacity to consent. The provider sent us an action plan outlining the improvements they would make. They said these would be in place by 31 July 2014.

At this inspection we found the service had taken action to address these concerns. CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. DoLS require providers to submit applications to a 'Supervisory Body' for authority to deprive a person of their liberty where this a necessity to promote their safety. We found that the provider had submitted three applications for DoLS to protect people, as they lacked the mental capacity to consent to receive care in the home.

Where people did not have the mental capacity to consent to care, staff treated them respectfully, and explained the actions they were taking to promote their safety and wellbeing. Senior care workers had received training in the Mental Capacity Act 2005 (MCA), and the manager and provider had a good understanding of the DoLS, but the majority of staff had not received this training. However, their actions demonstrated they were able to effectively implement the principles of the MCA. A relative told us "Staff always ask before doing things" and one person told us "You can go where you want, roam where you want".

People's health needs had been identified in their care plans, and guidance and actions for staff to follow were clearly documented. One relative told us their loved one had been referred to the GP because of weight loss. Care plans documented people's food preferences and needs, such as diabetic or soft meals. The cook had a good knowledge of each person's likes, allergies and needs, and explained how they adjusted meals to meet these. We observed people were supported to eat when and where they wished. At lunchtime staff engaged people in conversation, and supported them without rushing them. Staff were aware when it was important to encourage or monitor food and fluids, and charts had been completed as required to record dietary intake.

All the people we spoke with were complimentary about the food provided. People told us they were given choices, and staff understood their preferences. One relative told us there was "Lots of choice, they go out of their way to cook what [my relative] likes". We observed one person change their mind several times over a meal choice, and staff supported these changes to ensure they received a meal they would enjoy. The cook confirmed "If they don't want what's cooked, I cook them what they fancy. We go with their likes, and encourage variety".

Staff meetings, daily handover between shifts and the communications book demonstrated that staff usually communicated effectively to share information. We

Requires Improvement

Is the service effective?

observed a handover where changes to people's needs or wellbeing were clearly shared, such as levels of agitation and referrals to health professionals. However, it had not been communicated that one person had refused their lunch on the day of our inspection. When the person told staff on a later shift that they were hungry, staff did not realise this was because they had missed a meal, and told the person to wait for tea until we intervened to explain on their behalf. Staff then supported this person to choose a snack. This indicated that although a communication system was in place, it did not always work effectively to ensure all staff were informed of people's welfare or needs.

Records demonstrated that people were supported to attend planned health appointments, for example for hospital check ups. People were able to see the GP or district nurse in the home if they were ill, and referrals to health professionals, such as the occupational health therapist, were made to promote people's health and welfare. Staff followed guidance from these health professionals to meet people's health care needs.

Good

Is the service caring?

Our findings

People told us they were happy living in their home and said staff were "Kind, gentle and patient", and looked after them well. We spoke with relatives, who were complimentary about the care provided for people. One relative told us the staff were "Wonderful". We noted all six relatives who had responded to the provider's satisfaction survey in August 2014 had made positive comments about the care people received, and indicated that they would recommend the home to others.

Staff were caring and respectful. They understood people's individual needs and preferred ways of communicating. People's care plans provided staff with information on how to support people to enable them to communicate their wishes and make daily decisions. For example, one care plan noted 'Provide reassurance and time to allow expression of thoughts and ideas'. Staff gave people time to express themselves. Staff met people's eyes, smiled and used touch to reassure people. This was especially important to people with dementia who were unable to understand or contribute to verbal conversations.

Although staff were under pressure to complete tasks, people were given time to do things at their own pace. This meant they were enabled to enjoy their daily routine. We saw one person was woken gently and reminded that it was lunch time. The care worker sat and chatted with them until they were fully awake and able to make their way to the dining room. They were treated with patience and respect without being rushed.

People told us their dignity was promoted, and they were discreetly supported to attend to their personal needs. For example, when one person's clothing rode up during their transfer to a chair, care workers quickly readjusted their clothing to ensure their dignity was maintained. Care workers had recently received training in dignity, and gave several examples of how they would ensure people were treated respectfully.

People were encouraged to take part in daily household tasks that made them feel useful. People helped to prepare the dining room at lunchtime by laying out tablemats, napkins and condiments. Staff thanked people for their assistance, demonstrating that their actions were important and valued.

People's told us staff understood their wishes. Care plans documented people's likes, dislikes and preferences. They were individualised to reflect each person's needs and wishes, and provided guidance for staff to ensure care was provided as people requested. For example, care plans noted the time the person preferred to get up or go to bed, what assistance they required with personal care, and activities they enjoyed. Staff understood people's individual needs, and the way they spoke of them showed us they recognised and respected people's individuality. One person told us that they preferred to stay in their own room. Staff had encouraged them to socialise, but respected their choice to remain on their own.

People were encouraged and supported to maintain and build their independence. Care plans documented when people required assistance or prompting, and when to encourage people to undertake activities independently. We observed staff gave people the opportunity to undertake tasks independently, and praised their efforts. People felt pride in their accomplishments and were able to be as independent as they wished to be.

Relatives and friends were able to visit their loved ones throughout the day, and were welcomed into the home by staff. People met their visitors in their rooms if they wanted privacy. This meant people could speak with visitors confidentially if they wished, and visitors were encouraged to maintain meaningful relationships with their loved ones at times convenient to them.

Requires Improvement

Is the service responsive?

Our findings

At our inspection in May 2014 the provider did not always update people's care plans to ensure they reflected people's current needs. There were not enough opportunities for people to follow their interests and take part in social activities. We were concerned that people and their relatives had not been given the opportunity to formally provide feedback about the quality of their care. The provider sent us an action plan outlining the improvements they would make which they said would be in place by 31 July 2014.

At this inspection we found the service had taken steps to address these concerns but some improvements were still required.

People's choices, likes and dislikes were included in their care plans, demonstrating that people or their representatives had been involved in their initial care needs assessment. People's needs had been reviewed monthly, and care plans had been updated to reflect people's current needs. However, it was not always documented how people or their representatives had been involved in decisions about their care. The manager and provider explained to us how people and their representatives were involved in care planning, but documents did not reflect this involvement.

An activities book documented each person's engagement with the activities provided, but staff had not always recorded the activities people participated in. The purpose of the book was to enable staff to review which activities were more popular, and to understand each person's favoured activities, enabling them to provide a range of activities based on people's preferences. By not completing updates in this book, staff may not be informed of how to vary activities to meet people's indicated preferences.

People were mostly satisfied with the activities available to them in the home. Although many activities were held in groups, staff also spent time chatting with people on a one to one basis and assisting with individual activities when time allowed. We observed people joining in group and individual activities during our inspection, including exercises, a quiz and reminiscence. A care worker explained "We vary activities to people's mood. We ask them what they would like". People appeared to especially enjoy their dedicated one to one time spent with staff, and several people told us how important this was to them.

Church services were held in the home monthly, and a hairdresser visited every fortnight. However, some people did not feel there were sufficient opportunities to get out and about in the local community. One person said "You sometimes can't do what you want, because there aren't enough staff". We did not see evidence that people were encouraged or supported to engage in activities in the local community.

Monthly residents meetings were held. The manager or provider attended, so that people could raise concerns or issues directly with them. Minutes demonstrated that people had the opportunity to discuss and comment on agenda items such as activities and menu choice, and to raise concerns. The meetings were used as an opportunity to inform people of changes to the home such as planned refurbishments, and to introduce new residents or staff. The manager and provider told us how people's feedback would be considered before deciding on an action that may impact on others. The provider told us that they were looking into options to increase community involvement in response to comments raised in the satisfaction survey in August 2014.

A relative told us that a concern they had raised informally had been dealt with to their satisfaction, although it had not been recorded. Another relative had noted on their survey feedback that a complaint they had made had been dealt with effectively. The provider's Complaints Policy explained how complaints would be dealt with confidentially, and documented how the provider would address the complaint through investigation to resolution.

A complaints file permitted people to raise concerns anonymously if they did not wish to make a formal complaint. However, this meant that the manager investigating the concern was not able to respond directly to the person raising the concern. Therefore people were not aware of any actions taken in response to the anonymous complaint raised. We saw this had previously been used by staff to escalate their concerns. Staff told us they did not feel their concerns had been resolved. The

Requires Improvement

Is the service responsive?

provider explained the actions they had taken to resolve complaints raised in this file, and told us they would change the format to ensure a response could be provided to demonstrate that they had addressed concerns raised.

Requires Improvement

Is the service well-led?

Our findings

At our inspection in May 2014 the provider did not have quality assurance systems in place to ensure that continuous improvements were made to the service. The provider sent us an action plan outlining the improvements they would make which they said would be in place by 31 July 2014.

At this inspection we found the service had taken action to address these concerns, but some improvements were still needed.

Records did not always document that people had been involved in or consented to their care and support. Care plans did not reflect the involvement of people or their representatives, and people's preferred activities had not been recorded. Information, such as complaints, were not always kept securely to maintain confidentiality. A lack of detailed records meant that people's wishes, preferences and views may not always be taken into account when providing their care and treatment. A lack of confidentiality could dissuade people from raising concerns with the provider or manager, and so impact on their wellbeing.

Where relatives had consented to care for their loved ones, documentation did not evidence that they were able to lawfully consent on the person's behalf. Best interest decisions had not been clearly recorded to evidence inclusion of people's known wishes or preferences. A best interest decision is made by professionals, care workers, relatives or others with professional skills and knowledge of the individual, to ensure a decision the person lacks mental capacity to make themselves is taken in accordance with their best interests and known preferences.

The manager and provider were able to explain the process followed to assess whether people had mental capacity to make an informed decision, and best interest decision-making if it had been assessed a person lacked mental capacity for this. However, records did not reflect that these processes had been followed. This meant that people's records may not clearly document care and support guidance reflecting decisions made in the person's best interest when they lacked mental capacity to make their preferences known.

The provider did not ensure people were protected from the risks of inappropriate care and support, because information about them was not always maintained accurately, or kept securely. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

The new manager had implemented some quality assurance systems to identify factors that might impact on the delivery of quality care to people. These included feedback from people and relatives, and building, environmental and staffing audits. Where issues had been identified, such as staff vacancies, an action plan demonstrated the actions planned or taken to address the issue. For example, we saw it was noted that staff supervisions were being progressed, and that two staff vacancies had been identified. However, although the provider told us that recruitment was "ongoing", we did not see evidence in the action plan that staff recruitment had been progressed.

The time the manager spent providing support and care for people impacted on the time available for them to drive improvements to the home. The manager had completed monthly audits, for example regarding infection control, medicines management and staffing, but the only issue identified from these audits referred to the need to recruit two additional care workers. The audits were not sufficiently robust to identify all areas of improvement required to provide people with a high quality of care.

The registered manager had left in March 2014. The person managing the home since July 2014 had submitted their application to become a registered manager to the CQC. People were able to spend time with the manager and provider, who invited them to join them in the office if they wished. This meant the leadership was visible and approachable in the home.

The manager explained how they promoted good practice through demonstration while supporting people, and addressed poor practice through confidential discussions with those involved. The management promoted core values, such as privacy, dignity, choice and fulfilment, and recognised and referred to these in policies and documents, such as the service's statement of purpose. These core values were included in staff training, and staff displayed them when they supported people. One care worker told us "I feel inspired by the manager", and another told us "The manager puts in a lot of hours, and goes the extra mile. They take on extra to help us out".

Requires Improvement

Is the service well-led?

Staff told us the manager and provider listened to their comments, and usually acted on them. However, they did not always feel that that the provider understood the key challenges they faced. Staff did not have confidence that when concerns and risks prevented them from providing a high quality of service for people, the provider would address these promptly when informed. All the staff we spoke with raised concerns that people's care was impacted by low staffing levels. They told us they had raised these concerns with the provider, but the provider had not taken effective actions to address their concerns.

We discussed an issue with the provider that a member of staff had raised with us regarding security of the home to ensure people's safety. The care worker stated they had previously raised this with the provider, and that their concern had not yet been addressed. The provider explained the actions they had taken to ensure people were not at risk, but acknowledged that they had not responded back to the member of staff to explain the actions and decisions taken. They told us they would do so.

Staff meeting minutes demonstrated that staff had the opportunity to raise issues and influence actions and decisions. For example, the October staff meeting minutes described how a change to shift patterns had been discussed, but as staff comments were varied, the change would not be implemented until all staff had the opportunity to make their views known, and would be discussed again at the next staff meeting.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse People had not been safeguarded against the risk of abuse because the provider had not identified possible abuse, or prevented it before it occurred. Regulation 11 (1)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff People were at risk of unsafe care and treatment because staff did not receive appropriate training to deliver care and treatment to people safely. Regulation 23 (1)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records People were not protected from the risks of unsafe or inappropriate care arising from the lack of proper information and documentation recorded accurately in relation to their care and treatment, and information was not always stored securely. Regulation 20 (1)(a) (2)(a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **There were not sufficient skilled and experienced staff available to meet people's identified health and welfare needs. Regulation 22**

The enforcement action we took:
We have asked the provider to take actions to ensure there are sufficient staff available, with the required skills and experience, to meet people's identified health and welfare needs. They must complete this action by 31/01/2015.