Podsmead Residential Care Limited

Overleat Residential Care Home

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?	Inadequate

Overall summary

Overleat Residential Care Home is registered to provide accommodation for persons who require nursing or personal care for up to 13 older people who are living with dementia. People living at the home were in the early stages of dementia. Nursing care is not provided by the home, the local community nursing team provide this service.

This unannounced inspection took place on 4 August 2015 when there were nine people living at the home. The service was last inspected in July 2013 and was meeting the requirements at that time.

There was no manager registered at the service. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered

Summary of findings

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. The manager who had been registered at the home had last worked there in October 2014. A manager was employed and worked until 31 July 2015. They did not register with the CQC. A new manager had been appointed but had not yet applied to be registered.

Prior to this inspection we received concerns that staff were working at the home without satisfactory criminal records checks having been received. We found that staff were working at the home who had not had the required recruitment checks completed. We were also told that one member of staff had been heard shouting at people living at the home. Staff from the local authority visited the home prior to this inspection to look into the concerns about people being shouted at. They found no evidence to support the allegation that people were being shouted at, but did have concerns about staffing levels and the care records. We discussed the issue of staff shouting at people with the manager who had previously worked as care staff. They told us they had never had any concerns about other care staff and no-one living at the home had ever reported any concerns to them. Following our inspection staff from the local authority's quality team began working with the new manager to address the issues identified.

There were no effective quality monitoring systems in place. No audits had been undertaken in relation to medicines or accidents. Records relating to people's care were not well organised or reviewed appropriately. A number of records were not accurate or kept up-to-date. This included care plans and risk assessments. People had not been involved in developing the service and had not been asked for their opinions on the quality of care provided.

Staffing levels were not sufficient to meet people's needs at all times and staff recruitment systems were not robust. There was no system to identify when staff training updates would be required. We discussed these matters with the registered provider and the manager. The registered provider told us they had "taken their eye off the ball" and had thought the previous manager was addressing the issues.

People were not protected in the event of an emergency. Information on how to safely evacuate people from the building was not available. Information relating to the maintenance of the fire protection system was not available. It was not possible to check if the system had been correctly maintained or any routine checks carried out. Following this inspection we asked the fire service to visit the service and give their advice. The registered provider has since told us the fire service had visited and made some recommendations, which the registered provider was addressing.

Records in relation to risk assessment and management were incomplete. For example, one person who had been recently admitted had limited mobility and independently used a wheelchair. No risk assessments had been completed in relation to moving and transferring, pressure area care or independently accessing the community. However, the person told us staff were aware of their needs in relation to pressure area care and how to ensure transferred safely. They were also aware of the risks presented by accessing the community and went into the town most days on their own or with friends.

People's needs were met, but this did not always happen in a timely manner as there were insufficient staff on duty at times. At the time of this inspection there were nine people living at the home. Two people spent all their time in bed. Four people required two staff to help them with personal care or moving and transferring. Rotas showed there were two care staff on duty plus the manager on duty during the week. At weekends when the manager did not work, there were only two care staff on duty. Staff told us that they were able to meet people's personal care needs, but had to prioritise things in order to do so. They told us that there had been a shortage of staff, but that new staff were due to be employed. Prior to us finishing the inspection the registered provider agreed to ensure there would be three care staff on duty when the manager was not working at the home.

Records relating to people's nutritional intake were not robust. Where people had been identified as being at risk from malnutrition and dehydration food and fluid charts were used to monitor the person's intake. However, these were not being completed fully or in accordance with the plan of care. However, people were supported to

Summary of findings

maintain a healthy balanced diet. People praised the standard of food provided and told us "the food is very good...well cooked" and "the food is delicious....very nicely cooked....you get three veg per meal".

The environment needed updating and tidying and was not entirely suitable for people living with dementia. Bedroom doors had no identification by colour or numbers to enable people easily find their own rooms. There were few signs indicating where toilets were located and there was no calendar or clock to help people orientate themselves to the date and time. There was limited access to outside space as people could not safely leave the home without staff support. The driveway was uneven and open to the road. The rear access was uneven and there were building materials around the area. There were some seats at the front of the property, but people could not access this without the support of staff.

Staff did not receive support and supervision to enable them to effectively care for people living at the home. Two staff that we spoke with told us they had never received any supervision from the manager or registered provider. None of the four staff files we looked at contained evidence of supervision or appraisal.

Staff had not received training in relation to the Mental Capacity Act 2005 or the associated Deprivation of Liberty Safeguards. Some people were living with dementia and there was doubt as to whether they had the capacity to make some decisions. We did not see any evidence that decisions were being made that were not in the person's interest and saw throughout the inspection staff offering people choices and options. However, where people need to make some decisions, an assessment of their capacity to make a specific decision must be made, and records should demonstrate that where decisions are made on behalf of people, they are made in their best interests with the involvement of others. Staff were not doing this at Overleat.

People told us they felt staff were caring. Comments included, "Very good here they look after you...they care for you and are kind to me".

Records in relation to the care and support people should receive were confusing and information was not easily accessible. Although people told us staff knew their personal care needs, there was no recorded evidence people had been supported to say how they wanted to receive their care. The manager told us they were planning to start using a new care planning system and some people had a 'new' style plan. However, they had not been fully completed and reviewed.

Staff were aware of people's preferences and arrangements had been made to ensure they were respected. For example, a member of staff who would have been 'sleeping' stayed on full waking duty to enable one person to go to bed at the time they preferred. One person had been able to bring their pet with them when they moved in.

People did not benefit from individual activity plans to ensure they had meaningful activities to promote their wellbeing. Information about the person's life, the work they had done, and their interests was limited so could not be used to develop individual ways of stimulating and occupying people. There were no games, books or puzzles around that people could take advantage of. Although there was no regular programme for social interaction staff told us they did spend some time with people. One staff member told us "I like to just sit with them....at the weekends I do this...I bring in a selection of films and residents choose. There is a piano player booked sometimes".

There was no evidence that the service listened and learned from people's concerns and complaints. The manager did not know if there had been any recent complaints and there was no complaints file. However, people told us they knew how to raise a concern if they needed to.

People were protected from the risks of abuse. Staff demonstrated a good knowledge of different types of abuse. They told us how they would recognise abuse, and what they would do if they suspected abuse was occurring within the service. People told us they felt safe and one said "staff are not rude, cruel or unkind to me".

Medicines were stored safely and records were kept for medicines received and disposed of. Medication Administration Record (MAR) sheets confirmed oral medicines had been administered as prescribed. Arrangements for the application of topical creams ensured people received them as prescribed. For example, records contained a body map that indicated where the cream should be applied.

Summary of findings

There was evidence that staff had received training in a variety of subjects including fire procedures, safeguarding people , health and safety and caring for people living with dementia. Although there was a system that showed when staff had received training, there was no way to identify when updates would be required.

People were supported to receive care from a number of visiting healthcare professionals. Care notes indicated people had received visits from GPs, community nurses and dentists. One visiting health care professional told us they felt people's health care needs were well met.

They was much chatter and laughter with staff and people sharing stories about their past. Staff knew people well, what their needs were and how people liked their needs to be met. People's privacy was respected and all personal care was provided in private. One person told us that when staff helped them with their bath, staff respected their dignity.

The visitor we spoke with told us that they could visit at any time, were always made welcome and sometimes had meals with their relative. They also told us staff discussed their relatives care with them and were always informed about any changes to their relative's health and welfare. One person told us "my visitors are made very welcome".

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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?

Requires improvement

Aspects of the service were not safe.

Robust recruitment procedures were not in place.

People's needs were not met by ensuring there were sufficient staff on duty.

Risks to people's safety were not well managed.

People's medicines were managed safely.

People were protected from the risks of abuse.

Risks to people's health and welfare were well managed.

Is the service effective?

Requires improvement

Aspects of the service were not effective.

Records were not robust enough to ensure staff could determine if people were receiving effective care.

People were not supported by staff who displayed a good understanding of the principles of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People benefited from staff that were knowledgeable in how to care and support them.

People were supported to maintain a healthy balanced diet.

People were asked for their consent before staff provided personal care.

Is the service caring?

Good

Aspects of the service were not caring.

People and their relatives were not supported to be involved in making decisions about their care.

People's needs were met by kind and caring staff.

People's privacy and dignity was respected and all personal care was provided in private.

Visitors told us they could visit at any time and were always made to feel welcome.

Is the service responsive?

Requires improvement

Aspects of the service were not responsive.

People's care plans were not comprehensive and were not reviewed regularly.

People received care and support that was responsive to their needs.

Summary of findings

People were confident that if they raised concerns these would be dealt with quickly by the manager.

Is the service well-led?

Inadequate

The service was not well led.

There had been a number of changes to the management of the home and there were no effective quality assurance systems in place.

A condition of registration for this service is to have a registered manager. Overleat has not had a registered manager since October 2014.

Overleat Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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 4 August 2015 and was unannounced.

The inspection team consisted of one Adult Social Care (ASC) 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. The expert-by-experience on this occasion had experience of dementia care.

Before the inspection we gathered and reviewed information we hold about the provider. This included information from previous inspections and notifications (about events and incidents in the home) sent to us by the provider.

During the inspection we spoke with seven people using the service, one visiting relative, five staff, the manager and registered provider. We also spoke with two health and social care professionals and staff from the local authority who had commissioned some placements for people living at the home.

We observed the interaction between staff and people living at the home and reviewed a number of records. The records we looked at included people's care records, the provider's quality assurance system, accident and incident reports, staff records, records relating to medicine administration and staffing rotas.

Requires improvement

Is the service safe?

Our findings

We found that improvements were needed to the recruitment procedures and to record keeping in relation to risks, risk management and evacuation procedures.

People were not protected from the risks of unsuitable staff being employed at the home. There was no policy in place to ensure all employees were subject to the necessary checks which determined that they were suitable to work with vulnerable people. The four staff files we looked at contained varying amounts of information. Two files did not have a criminal records check. The staff had worked at the service for over eight months before a check was applied for. One staff member had worked at the home unsupervised for over two weeks prior to the receipt of their check. We had also received information from a person who had worked at the home for over six months without a criminal records check being obtained. Only one file contained evidence that the staff member was physically and mentally fit to perform their duties. Where offences had been identified on criminal records checks there was no evidence that the information had been assessed to determine if the staff presented a risk to people living at the service. References had not been obtained for any of the four staff whose files we looked at.

This was a breach of Regulation 19 (1)(a) (2)(a) (3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff whose files we looked at had been employed by the previous manager. The newly appointed manager was aware of the need to ensure staff did not work unsupervised before a satisfactory criminal record check and other required information had been obtained.

Not all records relating to risk and risk management were completed as they should be. For example, although actions were being taken to manage risks to people such as from dehydration, the records of one person were not always maintained as their care plan stated they should be. This person's care plan indicated they should be offered fluid every hour and this should be documented on the fluid chart. On one day the chart showed entries for 8am, 10am, 12noon, 3pm and 5pm only. Staff were confident that this person was having enough to drink, and records relating to weight and observation of people confirmed this. However, the plan to ensure this person received drinks hourly was not being followed, or was not accurate. Another person who had recently been admitted did not have risk assessments or records in place in relation to their moving and transferring needs, or in relation to the risks associated with them going out independently in their wheelchair.

Another person had a longstanding medical condition. There was no risk assessment in place in relation to their condition and the associated care plan had last been updated in June 2014. However, their condition was being monitored by the community nursing team who were visiting daily and gave staff directions with regard to the person's care.

Some other risks to people had been assessed. For example, one person's moving and transferring and pressure area risk assessments had been completed in April 2015. Although, these had not been reviewed since that time pressure relieving equipment was in place to minimise the risk of people developing pressure areas. Staff were also aware of how to minimise risks and told us they ensured the person's position in bed was changed regularly. However, each person must have an accurate record of their care and treatment which must include decisions taken in relation to the care and treatment provided.

Although staff had received fire training and demonstrated a good understanding of what to do in case of fire, records relating to the actions to take for each person if there were a fire were not completed in enough detail. Information relating to the maintenance of the fire protection system was not available.

This was a breach of Regulation 17(1) (2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs were met, however they sometimes had to wait as there were insufficient staff on duty. No assessment tool was used to determine the number of staff required to meet people's needs. At the time of this inspection there were nine people living at the home. Two people spent all their time in bed. Four people required two staff to help them with personal care or moving and transferring. Rotas showed there were two care staff on duty plus the manager on duty during the week. A cook was on duty seven days a week. At nights there was staff member and one sleeper available in an emergency. At weekends when the manager

Requires improvement

Is the service safe?

did not work there were only two care staff on duty. Staff told us that they were able to meet people's personal care needs, but had to prioritise things in order to do so. They told us that there had been a shortage of staff, but that new staff were due to be employed. Prior to us finishing the inspection the registered provider agreed to ensure there would be three care staff on duty when the manager was not working at the home. Following the inspection the manager informed us more staff were being recruited in order to maintain agreed staffing levels.

This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected from the risks of abuse. Staff demonstrated a good knowledge of different types of abuse. They told us how they would recognise abuse, and what they would do if they suspected abuse was occurring within the service. Staff knew they could contact the police or the local safeguarding people teams and told us the contact numbers were displayed on the staff notice board. Staff told us "I know the steps and I would whistle blow...I know about CQC and I would report and "I would whistle blow". However, not all staff had received safeguarding training.

People told us they felt safe and one said "staff are not rude cruel or unkind to me". Another told us "I use a walking stick, they supervise me safely". A visitor told us "I have never had an issue with safe care. I have been coming for three years."

Medicines were stored safely and records were kept for medicines received and disposed of. Medicines were stored in a locked cupboard in a locked room. Medicines that required refrigeration were stored appropriately and fridge temperatures were recorded and checked. People received their medicines safely and on time. Some people's medicines were monitored by the community nursing team who visited daily. Clear records were maintained by the service as requested by the nursing team. However, hand written entries on MAR sheets were not always double signed. This meant there was not always an audit trail to show that checks had been conducted to ensure that what had been written on the MAR sheets was what had been prescribed.

Medication Administration Record (MAR) sheets confirmed oral medicines had been administered as prescribed. Arrangements for the application of topical creams ensured people received them as prescribed. For example, records contained a body map that indicated where the cream should be applied.

Requires improvement

Is the service effective?

Our findings

We found improvements were needed in relation to the environment, staffing levels, staff training and supervision, the implementation of the mental capacity act and deprivation of liberty safeguards and to the environment.

The environment was not entirely suitable for people living with dementia. Although people living at the home were in the early stages of dementia, no assessment of the environment had been made. Bedroom doors had no identification by colour or numbers to enable people easily find their own rooms. There were few signs indicating where toilets were located and there was no calendar or clock to help people orientate themselves to the date and time. There was limited access to outside space as people could not safely leave the home without staff support. The driveway was uneven and open to the road. The rear access was uneven and there were building materials around the area. There were some seats at the front of the property, but people could not access this without the support of staff.

Although staff said they felt supported by the manager and could discuss any concerns at any time, staff did not receive support and supervision to enable them to effectively care for people living at the home. Two staff that we spoke with told us they had never received any supervision from the manager or registered provider. None of the four staff files we looked at contained evidence of supervision or appraisal.

Staff had received some training including fire procedures, safeguarding people, health and safety and caring for people living with dementia. They had not received training in the Mental Capacity Act or in the Deprivation of Liberty safeguards.

Although there was a system that showed when staff had received training, there was no way to identify when updates would be required. The system showed that staff were up to date with most training, but that some staff needed updates in relation to moving and transferring. One staff member told us "There is lots of training coming up. I have just done fire training, food hygiene and medicines. I have NVQ3 and palliative care". However, the manager and registered provider told us that future training had been cancelled as the past few sessions that had been arranged had not been well attended. The registered provider told us that they were looking at other ways to provide training rather than holding sessions within the home.

This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they thought staff had the skills to meet their needs. One person told us "Lunch is downstairs...they help me get there ....it is very professional help".

The front door at Overleat was always locked. This action was taken to keep people safe. However it is also a means of depriving people of their liberty that requires authorisation. No applications for authorisation had been made to the local authority to ensure people were not being restrained unlawfully due to access to outside being restricted by locked doors.

The manager and staff told us that some people were living with dementia. This meant there was doubt as to whether they had the capacity to make some decisions. We did not see any evidence that decisions were being made that were not in the person's interest and saw throughout the inspection staff offering people choices and options. However, where people need to make some decisions, an assessment of their capacity to make a specific decision must be made, and records should demonstrate that where decisions are made on behalf of people, are made in their best interests with the involvement of others. Staff were not doing this at Overleat.

People were supported to receive care from a number of visiting healthcare professionals. Care notes indicated people had received visits from GPs, community nurses and dentists. One visiting health care professional told us they felt people's health care needs were well met. They told us "anything that I have asked for has been done" and "With regard to staff being concerned about health needs they always ask for advice".

People were supported to maintain a healthy balanced diet. People praised the standard of food provided. People told us "the food is very good...well cooked", "the food is delicious....very nicely cooked....you get three veg per meal", "I enjoy the food" and "We have very good meals....they

Requires improvement

Is the service effective?

know I don't like fish". The cook told us "this is a small home...there is no choice of menu but I know their likes and dislikes...they know they can ask for anything". One relative told us their relation "eats very well".

We recommend the registered provider assesses the environment in relation to its suitability for people living with dementia.

Good

Is the service caring?

Our findings

People told us they felt staff were caring. Comments included, “Very good here they look after you...they care for you and are kind to me”, “the staff are great....they are gorgeous”, “They are a nice lot of carers...they work well together and are steady and happy”, staff are “absolutely lovely....they look after you very well...they are lovely kind ladies” and “the girls are very good”. People told us that they were well cared for, content and happy. People also told us that staff knew how they liked things done. One person told us how staff helped them care for their hair in the way they liked. Another person told us staff knew how they liked their personal care needs attended to.

Staff told us they enjoyed working at the home and one member of staff told us “If my mum was alive I would have her here”. Another told us “It’s very good working here....everyone is loving and hands on we give kisses and cuddles”. A visitor told us “the staff are sweet...kind especially to the very old, it is not institutionalised here”.

There was much chatter and laughter with staff and people sharing anecdotes about their past. Staff knew people well, what their needs were and how people liked their needs to be met. Staff told us about one person with communication difficulties, who was described as ‘proper Devon’ as they had lived all their life in Devon. Staff told us the person liked to hear the staff member’s Devon accent which often got a positive response from the person. One relative told us staff always spoke nicely to their relation, always treated them with care and were very, very patient. They went on to say they felt their relation “couldn’t be better cared for”.

People’s privacy was respected and all personal care was provided in private. One person told us that when staff helped them with their bath, staff respected their dignity. People were supported to make choices about the clothes they wore and we saw people’s nails and clothes were clean. The hairdresser visited during our inspection and people were complimented by staff and other people on the way they looked after having their hair done.

Staff were aware of issues of confidentiality and did not speak about people in front of other people. When they discussed people’s care needs with us they did so in a respectful and compassionate way. Care records were written in a respectful and appropriate language.

The visitor we spoke with told us that they could visit at any time, were always made welcome and sometimes had meals with their relative. They also told us staff discussed their relatives care with them and were always informed about any changes to their relative’s health and welfare. They also told us they were regularly consulted about their relation’s care. One person told us “my visitors are made very welcome”.

Requires improvement

Is the service responsive?

Our findings

People were at risk of not receiving care that met their needs. Although staff were aware of some needs care plans were confusing and information was not easily accessible. For example, staff were aware of the help one person needed with their personal care, but were unaware the person liked to listen to classical music. There was no evidence people had been supported to say how they wanted to receive their care. The manager told us they were planning to start using a new care planning system and some people had a 'new' style plan. However, they had not been fully completed and reviewed.

There was limited information available about one person who had been admitted to the home in June 2015. Some information was available from the care service the person had lived in before. This had not been reviewed since they had been admitted to the service. No risk assessments had been completed, and the sections of the care plan entitled 'My Life' and 'How to communicate with me' had also not been completed. However, the person was able to communicate well and was able to tell staff how they liked their needs to be met.

One person's 'new' care plan said they were able to fully communicate their needs and preferences. We saw that the person was no longer able to fully communicate, but their care plan had not been updated to reflect this. The section entitled 'How to help with my care had not been completed. One person's 'new' care plan contained details of how to communicate with them and how to help with their care, but the information had not been reviewed since February 2015.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, staff were aware of people's preferences and arrangements had been made to ensure they were respected. For example, a member of staff who would have been 'sleeping' stayed on full waking duty enable one person to go to bed at the time they preferred. The person told us "a carer is employed to cover the extra hour after everyone else has gone to bed". Staff were also aware of this person's wish to move to a larger bedroom and were trying to arrange this. One person had been able to bring their pet with them when they moved in.

Other people also told us that they were able to get up and go to bed when they chose and have a bath or shower as they wished. People told us "the care is good I can't complain.....I have a bath each week", "They know me as an individual" and they ask what time I want to go to bed....I couldn't complain". One person with limited sight had access to a speaking watch and clock.

People did not benefit from individual activity plans to ensure they had meaningful activities to promote their wellbeing. Information about the person's life, the work they had done, and their interests was limited so could not be used to develop individual ways of stimulating and occupying people. There were no games, books or puzzles around that people could take advantage of. People told us they would like more to do, but could not tell us what they would like. Although there was no regular programme for social interaction staff told us they did spend some time with people. At times during our inspection we saw that staff spent time chatting with people. One staff member told us "I like to just sit with them....at the weekends I do this...I bring in a selection of films and residents choose. There is a piano player booked sometimes".

Some people were able to organise their own social activity and told us "entertainment, I'm not interested...I do my exercise". Another person regularly went into town independently and also visited their local church. There was no record of people's religious needs, but communion was held each month in the home's lounge.

There was no evidence that the service listened and learned from people's concerns and complaints. The manager did not know if there had been any recent complaints and there was no complaint file. However, people told us they knew how to raise a concern if they needed to.

We recommend the registered provider researches and implements guidance in relation to engaging people in meaningful activities.

Inadequate

Is the service well-led?

Our findings

It is a condition of the service's registration that a manager is registered with the Care Quality Commission. Overleat did not have a registered manager. The manager who had been registered at Overleat had left in October 2014. Another manager was engaged and left on 31 July 2015. They did not register with the Care quality Commission (CQC). A new manager had been appointed but was not registered. The registered provider spent most of the week at the service but was not involved in the day to day management of the service.

There were no effective quality or risk monitoring systems in place. No audits had been undertaken in any area including medicines or accidents. Records relating to people's care were not well organised or accessible. A number of records were not accurate or kept up-to-date. This included care plans and risk assessments. People had not been involved in developing the service and had not been asked for their opinions on the quality of care provided. There was no system to collect and evaluate people's views about the home. No meetings were held where people could contribute their views on the running of the home. People, their visitors and social and healthcare professionals were not regularly asked for their views on the quality of the care provided.

Information relating to the maintenance of the fire protection system was not available. It was not possible to check if the system had been correctly maintained or any routine checks carried out. Following this inspection we asked the fire service to visit the service and give their advice. The registered provider has since told us the fire service had visited and made some recommendations, which the registered provider was addressing. An assessment of the home in relation to the needs of people with dementia had not been undertaken and the environment needed updating and tidying.

There was no system for assessing how many staff were needed to meet people's needs and this meant that at times staffing levels were not sufficient to meet people's needs. Staff recruitment systems were not robust. There was no system to identify when staff training updates would be required.

This was a breach of Regulation 17 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed these matters with the registered provider and the manager. The registered provider told us they had "taken their eye off the ball" and had thought the previous manager was addressing the issues. They told us they planned to ensure the manager was registered as soon as possible and to put plans in place to address all the issues we had identified.

Since our visit to the home, the quality monitoring team employed by the local authority have begun visiting the home to support the manager to make improvements.

Staff told us they felt supported by the management team and that they enjoyed working at the home. One staff member told us "Staff communicate with each other well". Staff told us that requests for equipment dealt with quickly. For example the cook told us "the kitchen has everything I need...the owner responded to my request for a blender.....he's very good".

The home had notified the Care Quality Commission of all significant events which had occurred in line with their legal responsibilities.

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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed People who use services and others were not protected against the risks associated with unsuitable staff being employed. Regulation 19 (1)(a) (2)(a) (3)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance There was no system in place to assess, monitor and improve the quality and safety of the service. Regulation 17 (1) (2) (a). There was no accurate record in respect of people's care and treatment. Regulation 17 (1) (2) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People's needs were not always met in a timely way as there were not always sufficient staff on duty. Regulation 18 (1) Staff did not receive appropriate training, supervision or appraisal in order to enable them to meet people's needs effectively. Regulation 18 (2)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People did not receive care that was personalised specifically for them. Regulation 9.