Runwood Homes Limited

Stafford Hall

Inspection Report

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Overall summary

Stafford Hall provides services for up to 40 people who need assistance due to old age or dementia. At the time of our inspection there were 32 people living in the service. There is a registered manager in post.

People and staff told us that there was not enough staff working in the service. Although the service was fully staffed on the days of our inspection there were times when people's safety was compromised. Staff told us that when they were supporting people with their personal care needs, this frequently meant that it was not possible to have a member of staff free to be with people in the lounge to ensure that they were safe.

The registered manager told us that a tool was used to assess people's dependency levels; however there was no analysis of this to show how staffing levels were calculated to ensure that people's needs were met effectively. All of the people who used the service interviewed and all the staff spoken with, stated that there were insufficient staff numbers, there was no audit or plan to address these concerns.

The provider had a good system in place that recorded the number of incidents and accidents that had occurred each month, however we found there was no overall analysis of trends, such as falls at night which had a significantly higher occurrence rate. This trend had not been reviewed as to why this was happening and if this was linked to staffing levels.

From discussions with the manager about the environment it was evident that there was little recognition of the differing needs of people with or without dementia and therefore no plan or procedures to address these. This was particularly relevant to those who chose to spend time in their rooms, because they preferred not to mix with people with advancing dementia, some of whom had behaviour that challenged.

Health charts showed that overall people's health was being managed and monitored by staff. However bowel monitoring charts were not fully completed. The registered manager informed us that people's bowel movements were also recorded in the daily records. This dual recording process resulted in difficulties monitoring people's bowel movements appropriately and increased the risks to their health from constipation.

During the first day of our inspection we found areas of the home, equipment and appliances were dirty and unhygienic. When we returned the next day the registered manager had taken action to ensure that these items had been cleaned and were in working order. Although the provider had infection control audit procedures in place, the registered manager had not taken action to address previous issues relating to the provision of appropriate equipment and standards of hygiene.

The lack of robust quality assurance and governance of the service found at this inspection breached Regulations 10, 12, 15 and 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have told the provider to take at the back of the full version of the report.

The provider had systems in place to manage safeguarding matters, behaviour that challenged and medication which ensured people's safety. Staff had access to a safeguarding adult's policy and procedures and had a good understanding of the procedures and how and when to follow them. Individual behaviour plans had been produced providing guidance to staff which ensured people's behaviour was dealt with effectively and in a manner that respected their dignity and protected their rights. Appropriate arrangements were in place that ensured people who used the service received their medicines as prescribed.

People had been involved in discussions about what dignity meant to them. We observed that staff adhered to these principles during our inspection, recognising the diversity, values and rights of the people that used the service. Our observation of the interactions between people who used the service and staff were positive. Staff were respectful when talking with people, calling them by their preferred names and speaking discretely with them about their personal care needs.

The provider had systems in place which supported people and their relatives to manage end of life in a

Summary of findings

positive way. Documents showed that mental capacity assessments and best interests meetings had taken place, when decisions needed to be taken on behalf of someone who was deemed to lack capacity.

We found that staff were motivated, caring and well trained. Records showed that training had been provided to meet the specific needs of people who used the service, including dementia. Six staff had been trained to be dementia champions, which meant that they took a lead on promoting dementia care in the service.

People spoke positively about the range of activities in the service. The activities coordinator told us that their aim was to ensure that people had a pleasant and happy time. One relative said, "Activities are inventive and fun."

Staff and people who used the service told us that they felt the registered manager was approachable, and that they would feel confident to raise concerns with them and felt these would be addressed. We saw that people's complaints were investigated in a timely fashion. The outcome of these had been used to make improvements to the service.

The registered manager had asked relatives of people who used the service to complete a satisfaction survey. These surveys showed positive results about the service. Where issues had been raised, for example about missing laundry these had been dealt with through the complaints process, which demonstrated that the registered manager had used this feedback to improve the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Staffing arrangements in the service were not sufficient to keep people safe.

People were not protected from the risks associated with the prevention and control of infection.

Systems to manage accidents and incidents were not used effectively to keep people safe.

People who had behaviour that challenged others was dealt with effectively which protected their dignity and rights.

Are services effective?

The differing needs of people with or without dementia had not been taken into consideration. This was particularly relevant to those who chose to spend time in their rooms, because they preferred not to mix with people with advancing dementia, some of whom had behaviour that challenged.

Dual recording processes were not effectively monitoring and managing people's bowel movements and the risks to their health from constipation.

People were protected from the risks associated with nutrition and hydration.

Are services caring?

The service was caring because staff had the right approach. People were encouraged to make their views known about their care, treatment and support, and these were respected by staff. People and their relatives were positive about the care and support given.

People had their privacy and dignity respected.

Systems were in place which supported people and their relatives to manage end of life in a positive way.

Are services responsive to people's needs?

People had their care and support needs assessed and kept under review. Staff responded quickly when people's needs changed, which ensured that their individual needs were met.

People had access to activities that were important to them. These were designed to meet people's needs, hobbies and interests, which promoted their wellbeing.

Summary of findings

People's concerns and complaints about the service were investigated, responded to promptly and used to improve the quality of the service.

Are services well-led?

There was a lack of robust quality assurance and governance in the service to identify the lack of staff resources and trends in relation to falls.

The management team did not have systems in place to ensure that there were sufficient numbers of staff, with the right competencies, knowledge, skills and experience available at all times, to meet the needs of the people who used the service.

We saw that systems were in place that enabled open communication between the people that used the service, their relatives, managers and the staff.

Staff had received training which focussed on the specific needs of people who used the service.

Summary of findings

What people who use the service and those that matter to them say

We spoke with ten people who used the service. They told us that staff were kind and they respected their privacy and dignity. People told us they were happy with the care and support they received. One person told us, "The carers are all very kind, I have a nice room and everything is nice here." Another person commented, "The carers have all been good to me."

Of the ten people spoken with all raised concerns about staffing levels. One person told us, "I am quite happy here, but staffing levels could be better." Other comments included, "Staff do their best but that there's not enough of them" and "The staff do their absolute best, but they really don't have enough staff. There is an extra member of staff here and there, but the staff are at stretching point, I really don't know how they cope."

Three people told us that they felt there were not enough members of staff on duty at night. Two people told us that they had been woken up during the night to find another person in their room going through their belongings. They told us that they now kept their doors locked at night. Another person said that, "People wander about upstairs at night and they end up falling."

One person told us that they attended the 'Residents forum', where they had been asked what they thought about the food. They commented, "I was pleased that they asked me and that they valued my opinion." However, another person told us, the food was not "Always to my liking, I would really like an occasional treat, like a doughnut or some salmon." They told us that, "The menu was very much the same, and a treat now and then would be well received."

One relative said, "The home looks good and on the whole everything is OK." Another told us, "I am very happy with the home and with the manager, I have regular email contact with the manager about my relative's health and wellbeing and this works well." They also commented that, "My relative is well looked after and I am not aware of any concerns, I feel this is a very safe environment for my relative, I feel I made a good choice in selecting Stafford Hall for them."

People told us that the staff were kind and caring. One person told us, "I can't fault the staff, they all try very hard". Another person said, "Staff are wonderful, can't fault them". One person said that, "The younger carers were better than the older ones", but another person said that the younger carers were, "Very caring but they don't have time to sit and chat".

One person told us, "There are quite a few people here with dementia, two people in particular that can be difficult, I would like to have dementia training, so that I know more about dementia."

People told us that they were supported to go out in the community to places of interest, such as Hadleigh Castle, restaurants and for fish and chips.

One person on the first floor complained about, "Not being able to access the garden." This was because the door to the garden was a fire door, and had to be kept closed. One person told us that they had made a complaint and that this had now been "Sorted out".

Stafford Hall

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 regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process, under Wave 1.

We visited Stafford Hall on 07 and 08 May 2014. The inspection team consisted of two inspectors and an Expert by Experience who had experience of dementia services.

The service was last inspected 16 and 23 April 2013 and at the time was meeting all essential standards assessed during the inspection.

Before our inspection we reviewed the information we held about the service. We examined previous inspection reports and notifications received by the Care Quality Commission. Following a visit to the service, the local authority sent us a copy of a report which highlighted where improvements were needed to ensure that people were being treated with dignity and respect. This information helped us to plan our inspection.

We spoke with ten people who were able to express their views and three relatives who were visiting on the day of our inspection. We spent time observing care in both dining rooms and used the Short Observational Framework for Inspectors (SOFI). This is a specific way of observing care to help us understand the experiences of people who were unable to talk with us, due to their complex health needs.

We looked at records in relation to four people's care and medication. We also spoke with the deputy manager, eight care staff, a member of the catering team and a housekeeper. We looked at records relating to the management of the service, staff training records, and a selection of the service's policies and procedures.

Are services safe?

Our findings

During the first day of our inspection we found commodes soiled with faeces, an inoperable sluice, and a dirty hand basin. There were no racks or other suitable means of drying commode pots and urine bottles, following cleaning and disinfection. Records indicated that the kitchen had been deep cleaned before the day of our inspection; however we found that surfaces and the fridge were not clean. An additional fridge and freezer were located at the end of a corridor in the staff room; both of these appliances were dirty and unhygienic. When we returned the next day the registered manager had taken action to ensure that these items had been cleaned and were in working order. We asked the registered manager how infection control was managed in the service and how these met the requirements of the Health and Social Care Act 2008 - code of practice on the prevention and control of infections and related guidance. They were unable to locate or provide us with a copy of this guidance.

Although the provider had an infection control audit procedure, an audit of 30 April 2014 carried out by the registered manager had no date entered to show when a deep clean of the service had last been carried out. In this audit they had recorded that the provision of drying racks for commode pots and urine bottles, once they had been cleaned and disinfected was 'N/A' (Not applicable) to this service. The same response was recorded for procedures for regular laundering of communal hoist slings and handling belts. A previous audit of 11 November 2013 carried out by the provider's regional care director, identified these same issues relating to provision of appropriate equipment and hygiene. The audit carried out in 30 April 2014 showed that these had not been responded to by the registered manager.

We spoke with ten people who told us that there was not enough staff working in the service. Comments included, "They really don't have enough staff," and "The staff are at stretching point." Another commented, "Staff do their best but that there's not enough of them."

We spoke with eight care staff who confirmed what people told us about staffing levels. They told us that staffing levels were set with a care team manager each day shift supported by four care staff in the morning and three in the afternoon to meet the needs of 32 people. There were three care staff at night. The registered manager and deputy manager were mostly supernumerary to the staffing numbers. The deputy manager however did work some days as a care team manager when required.

The service had two lounge/dining areas, one large, and one small. People with dementia were encouraged towards the larger lounge. Staff told us that were instructed to have a member of staff present at all times in both lounges in order to supervise people. Although the service was fully staffed on the days of our inspection there were times when staff were not present in the main lounge / dining room because they were supporting people with their personal care needs. We observed a person in the larger lounge, take the handles of another person's wheelchair and spin them round several times. A visiting health professional, intervened to stop this happening, as there were no staff present.

The complaints log showed that in October 2013 a relative had raised a complaint about staffing levels in the afternoons. They had commented that, "If there is four it is OK, if there is not, it's not." We saw that as a result of the complaint an additional member of staff was added to the afternoon shift between the hours of six and eight pm. Evidence showed that the complainant was happy with this arrangement.

One person who used the service told us, "There used to be four care staff on duty in the afternoon, but this has now stopped, but I don't know why." This was confirmed in conversation with a member of staff, who told us that the staffing numbers in the afternoon, had been reduced from four care staff to three, but they still had the same number of people living in the service. They said this was an issue, particularly if a person was unwell or had a fall and needed to go to hospital, leaving two care staff to support the people in the service. This was confirmed in conversation with a person who used the service who told us, "There was not enough staff on duty to escort me to hospital, but I was OK with the paramedics." Three people said that there were not enough members of staff on duty at night. Two people said that other 'residents' had entered their rooms during the night and had woken them up, and that they now kept their doors locked. Another person said that people "Wander" about upstairs and they end up falling, and said this was because, "There is not enough staff on duty to keep an eye on them."

Are services safe?

A monthly audit of incident and accidents showed that from January to April 2014 there had been 48 falls, 25 of these had occurred at night, six of which required attendance by paramedics. These records showed that people had been 'found on the floor', in their rooms. Although there was a system in place that recorded the number of incidents and accidents that had occurred each month, we found there was no overall analysis of trends, such as falls at night which had a significantly higher occurrence rate than falls during the day.

The shortfalls we found breached Regulations 10, 12 and 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, and you can see what action we told the provider to take at the back of the full version of the report.

The provider's safeguarding adults and whistle blowing policies and procedures informed staff of their responsibilities to protect people from harm. Training records showed that staff had received updated safeguarding training. Staff spoken with had a good understanding of the procedures to follow if a concern was raised or if they witnessed abuse. Where a safeguarding concern had been raised, we saw that appropriate action had been taken by the registered manager to liaise with the local authority and the police to ensure the safety and welfare of the people involved.

Where people had been assessed as having behaviour that was challenging we saw that appropriate referrals had been made to the GP, neurologist and the community dementia nurse. Following these referrals individual behaviour plans had been produced. These plans guided staff on how to manage the person's behaviour effectively, whilst protecting their rights and dignity. Daily notes reflected incidents of aggressive behaviour were being well managed. Where people had been prescribed medicines on an 'as required basis' to help manage their behaviour, detailed protocols were in place to ensure it was administered safely.

Where people were not be able to make particular decisions because they did not have the mental capacity to do so, we saw that measures had been taken to make sure that decisions were made in the person's best interests. For example, we saw that one person had been assessed as not having capacity to tend to their own personal care and recognise the risks of self-neglect, and that in their best interests staff supported them to undertake their personal care needs.

We looked at four people's care plans which contained assessments of any risks to their well-being. These were being reviewed and covered a wide range of areas, such as moving and handling, falls, malnutrition and pressure ulcers. These assessments gave staff clear direction as to what action to take to minimise potential risks to people. For example, one person's pressure ulcer risk assessment showed the person's risk had increased due to gradual weight loss. As a result staff had made a referral to the dietician and plans were put in place after this person refused to eat.

The provider had arrangements in place for managing people's medicines. The policy and procedure was held in the medicines room and was accessible to staff for guidance on obtaining, handling, and administration of medication. We saw that medicines, including controlled drugs were stored securely and safely. Where people that had been assessed as having capacity they were supported to manage their own medicines.

A medication profile was in place for each person, listing their medication, a description and photograph of tablets or capsules, the times prescribed and a running total of medication received into the service. We looked at all people's Medication Administration Records (MAR) charts and saw that these had been completed correctly by staff. Monthly medication audits took place to check that medicines were being obtained, stored, administered and disposed of appropriately. These measures ensured that staff consistently managed medicines in a safe way, making sure that people who used the service received their medicines as prescribed.

Are services effective?

(for example, treatment is effective)

Our findings

We spoke with six people with rooms on the first floor who told us that they mostly remained in their rooms. This was because they preferred not to mix with people with advancing dementia, some of whom had behaviour that challenged. One person told us, "The service is not designed for people with dementia. There have been problems amongst people who live here because they do not understand the impact dementia has on a person's life."

Stafford Hall is an old building and not purpose built for older people or those living with dementia. Although the service had two lounges, people with dementia were encouraged to go to the larger lounge, leaving the smaller lounge for people without dementia. These lounges were the only communal areas available to the people who used the service. People told us that they were unable to access the garden area unless they were escorted by staff. Other than people's own rooms, there were no other assigned quiet areas and spaces available for people to spend time alone. From discussions with the manager about the environment it was evident that there was little recognition of the differing needs of people with or without dementia and therefore no plan or procedures to address these. This was particularly relevant to those who chose to spend time in their rooms.

The lack of robust quality assurance and governance of the service found at this inspection breached Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have told the provider to take at the back of the full version of the report.

Four people's care plans confirmed a detailed assessment of their needs had been undertaken by staff prior to their admission to the service. People and their relatives confirmed that they had been involved in this initial assessment, and had been able to give their opinion on how their care and support was provided. Information was clear and gave good guidance for staff to follow to meet people's individual needs.

A range of health charts were completed showing how these four people's health was being managed and monitored. However their bowel monitoring charts were not fully completed. The records of one of the four people reviewed indicated that they had twice been admitted to hospital with constipation. The registered manager informed us that people's bowel movements could also be recorded in the daily records. This dual recording process resulted in difficulties appropriately monitoring people's bowel movements and increased the risks to their health from constipation.

People's care plans contained information so that staff knew how to manage their specific health conditions, such as Parkinson's disease, diabetes and epilepsy. Staff told us that they had good support from three different doctors' surgeries and the district nurses, including the out of hours service for emergencies. Care plans were being reviewed at least monthly, or sooner if people's needs changed. Relatives and social workers were invited to attend these reviews. One relative who had attended a review commented, "I am very happy with the care my relative is receiving."

'My day' summaries provided an overview of people's needs and what was important to them. Relatives had helped to provide information about their past and important people in their life. This helped staff to provide personalised support to people living with dementia.

Ten people in the service were living with dementia which meant their needs were likely to change over time and sometimes quite rapidly. We asked staff how they were made aware of changes in people's needs. They told us that there were a number of ways in which information was shared, including a communication book, people's daily records and a verbal handover session at the beginning of every shift. Daily records provided a good description of how each person had spent their day. Any relevant health issues, their nutritional intake and their general wellbeing had been recorded. These records showed that staff were providing personalised care that met people's individual needs. Where a person's health had deteriorated or required specialist input, we saw that referrals had been made to the appropriate health professionals.

Appropriate moving and handling assessments were included in people's care plans. These assessments contained step by step guidance for staff to ensure that they supported people to move safely, including the make and model of equipment and type of slings to be used. Staff had been trained to use equipment so that they could help people to transfer safely. We observed staff transferring people appropriately and in a way that

Are services effective?

(for example, treatment is effective)

protected their dignity. For example, we saw staff cover a person with a blanket whilst transferring them from their wheelchair into an armchair in the lounge, to prevent people being able to see their underwear.

We observed people being served their lunch and noted that they were asked about their preferences of meals. People were provided with the level of support they needed to eat their meals and this was done in a relaxed manner and a pace that allowed the individual to eat and enjoy their meal. People were observed using equipment, such as plate guards and adapted cutlery, to maintain their independence. Catering staff were involved in serving meals, and people were offered second helpings. We spoke with catering staff who were aware of people's nutritional needs, including those who required special diets.

Care plans recorded people's dietary needs and the level of support they needed to ensure they received a balanced diet. Risk assessments, such as the Malnutrition Universal Screening Tool (MUST) had been used to identify where there were specific risks associated with people's nutrition. These assessments had been reviewed on a regular basis. Where people were at risk of malnutrition, referrals had been made to the dietician for specialist advice.

Are services caring?

Our findings

People told us that staff were caring and respectful of their privacy and dignity. People said they were treated well by the staff, and that they liked living at Stafford Hall. One person told us, "The carers are all very kind." Another commented, "The carers have all been good to me."

Dignity was promoted within the service to ensure people were treated with respect. A 'Dignity tree' was displayed on the wall in the corridor which showed people had been involved in discussions about what dignity meant to them. For example, one person said, "Dignity is privacy and being dressed right". Another said "Being nice, polite and respectful to other people and being given privacy". A third responded, "Being treated properly in personal care and to be looked after nicely". Our observations during the inspection showed that people looked well dressed and cared for, and staff were respectful when talking with people, calling them by their preferred names.

Dignity was discussed as a routine agenda item at staff meetings, with a different dignity focus each month. For the month of May, the focus for staff was 'Listen and support people'. Staff were aware of need for people's privacy, and we observed good practice, of staff knocking on people's doors before entering, and speaking discretely with people about their personal care needs.

Staff talked passionately about the people they supported. One member of staff described, how they supported people by putting themself in their situation, and what it would be like to be on the receiving end of the care that they provided. They said that they learned to 'bend' with how people were, recognising that all people are different, and said it was about knowing the person.

We spent time in the communal areas of the service observing the interactions between staff and people living at Stafford Hall. We saw that staff had very caring attitudes towards people and showed concern for their wellbeing. For example, a member of staff supported a person who was agitated during their mealtime; they sat holding their hand speaking to them in reassuring tones. The person's mood changed, they became relaxed and ate their meal with the support of the a member of staff. When another person became very anxious to get up; two staff were quick to assist. They established that they needed to go to the toilet. When they returned we saw that staff checked that they were settled before getting on with other duties.

The provider had systems in place which supported people and their relatives to manage end of life in a positive way. Documentation in people's care plans showed that their next of kin had been involved in discussions about preferences and wishes for their end of life. These had been clearly recorded. Assessments had been completed where people lacked capacity to make decisions about their end of life care. Meetings had taken place with the relevant people so that arrangements had been made in the person's best interests.

A 'Bereavement information pack' was available in the entrance hall, which provided good information to people and their relatives about what to do at the end of a person's life. This provided practical details about dealing with death and bereavement, including the contact details of different religious faiths to arrange funeral services.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Over the course of the two days we spent at the service we saw that people were provided with activities that kept them occupied. For example, we saw people were knitting, reading and watching television. A religious service was held; followed by an exercise group. A band arrived in the afternoon of the second day of our inspection providing entertainments as part of 'Victory in Europe' day celebrations. People were offered the choice to take part in these activities, and their decision was respected if they declined. The religious service and activities were well attended, and people were observed joining in singing and taking part in the exercise group, clearly enjoying the events.

We spoke with one of two activities coordinators employed at the service. They told us that they had an activities planner, but judged activities day by day depending on people's mood and who wished to attend. They described a range of activities, which included trips out to garden centres or other places of interest. The activities coordinator knew the people in the service well, including information about their past, and told us that they tried to plan activities that incorporated people's interests and hobbies. For example, they told us that one person loved reading books, and a mobile library service had been requested to visit the service weekly, so that this person was able to access books. People that chose to stay in their own room told us that they had plenty of visitors and that the activities staff popped in for a chat, discussed the newspaper and helped them to have a drink.

Both activities coordinators attended meetings with other activity coordinators from Runwood Homes Limited services, two to three times a year to network and share new ideas for activities. They told us that the service was a member of a national association for providers of activities for older people where they were able to find ideas for activities. They had also completed a six week therapeutic course designed for the wellbeing of people with dementia, which focused on sensory stimulation, as a means of enhancing people's communication; particularly for those at risk of social isolation due to their dementia. The activities coordinator told us that their aim was to ensure that people had a pleasant and happy time. They said that activities were discussed with people at monthly resident meetings so that they were able to give their ideas for future activities.

People were receiving care that was responsive to their needs. For example, we saw one person's pain management plan which showed that medication was changed to liquid form, where this person had difficulties swallowing tablets. Additionally, where people had developed pressure ulcers, we saw that they had been provided with the appropriate equipment and referred to the tissue viability nurse. Records showed that the district nurse regularly visited the service to support people's health and well being.

Appropriate professionals had been involved in the assessment and planning of people's care needs. For example, in one person's care plan and daily records showed that there had been deterioration in their health. The care plan had been regularly updated accordingly with clear guidance for staff on how best to support the person. Because this person had advanced dementia and had been assessed as not having mental capacity, this change in their health had been discussed with their family, the district nurse and a representative from NHS continuing healthcare. We saw that it had been agreed in the person's best interests that they would benefit from nursing care. The relative was being supported to look for a nursing establishment that could provide that level of care.

The provider's complaints policy and procedure contained the contact details of relevant outside agencies and also gave a list of advocacy services and their contact details. The complaints procedure was available in different formats on request, for example in large print for people with partial sight. Staff told us they were aware of the complaints procedure and knew how to respond to people's complaints. Staff and people who used the service told us that they felt the registered manager was approachable, and that they would feel confident to raise concerns with them and felt these would be addressed.

We looked at the complaints book and saw that since April 2013 there had been 22 complaints. We inspected the paper work associated with these complaints and saw these had been appropriately investigated in a timely fashion in line with the policy. The outcome of these complaints had been used to make improvements to the service. For example, a complaint had been made about

Are services responsive to people's needs?

(for example, to feedback?)

the lack of variety and quality of the food. We saw that a letter had been sent to the complainant from a regional manager outlining the provider's commitment to good nutrition. A survey was conducted to obtain feedback from people who used the service. Twenty two people responded to the survey, and as a result changes were made to the menu.

Are services well-led?

Our findings

The registered manager informed us that a dependency tool was used to assess people's dependency levels, as low, medium or high, however there was no analysis of this to show how staffing levels were calculated. There was not a system in place to assess and monitor that there were sufficient numbers of staff with the right skills on duty at all times to meet people's needs. All of the people who used the service that were interviewed and all the staff spoken with, stated that there were insufficient numbers, there was no audit or plan to address these concerns. Staff told us that 28 out of the 32 people using the service needed one or two care staff to manage their personal care, which frequently meant that it was not possible to have a member of staff free to be with people in the lounge.

A monthly record of accidents, for example the number of falls people had, was kept, however there was no system in place to analyse and respond to the data, to prevent further falls. The registered manager had not taken action to contact the falls team. Where they had identified a trend that a disproportionate number of falls were happening at night this had not been reviewed as to why this was happening and if this was linked to staffing levels.

The concerns raised by people who used the service relating to the mix of people with and without dementia were not acknowledged and therefore not addressed by the management. Neither was there sufficient consideration of the impact on people with dementia due to the layout of the building.

All the above indicated a lack of robust quality assurance and governance of the service and we found the service to be in breach of Regulations 10, 15 and 22 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010. The action we have asked the provider to take can be found at the back of this report.

We looked at the provider's Business Plan for 2014 which showed the improvements made by the service in the previous 12 months and where further improvements were needed. For example, this showed that the service had made improvements to care for people with dementia by training staff to become Dementia champions. Improvements had also been made to the induction of new staff to prevent high staff turnover and implementation of a fast track programme to develop staff for future managerial roles. An area for improvement identified the need for further dignity training and new dignity in care training was to be delivered. Dates had been arranged for staff to attend this training.

We found that the staff were motivated, caring, well trained and they told us that they felt supported in their work. Staff told us that they had completed a range of training that ensured they were able to carry out their roles and responsibilities. Records showed that training had been provided to meet the specific needs of people who used the service, including dementia. Six staff had been trained to be dementia champions, which meant that they took a lead on promoting dementia care in the service. The majority of staff had completed a nationally recognised health and social qualification at level 2 or above.

One member of staff told us that they felt the training they received was good. They commented that every day was different and that they were learning all the time. For example, they told us that a number of people living in the service had diabetes. They said although they had district nurse support, they had requested and were waiting for further training to have a better understanding about diabetes, with regards to diet and the symptoms to be aware of.

Staff said the manager treated them fairly and that they could approach them at any time if they had a problem or something to contribute to the running of the service. One member of staff told us that they had a lot of support from the deputy manager. Staff felt communication in the service was very good, and that they were always kept informed about changes in the service and new ways of working. All of the staff spoken with felt that issues in the service were dealt with in an open and transparent way. Staff confirmed that they had regular supervision where they had the opportunity to receive support and guidance about their work and discuss their training needs. They also confirmed that they had an annual review, which measured their individual performance.

In January 2014 the registered manager had asked relatives of people who used the service to complete a satisfaction survey. At the time of inspection, eight out of 33 relatives had completed and returned the surveys. These surveys showed positive results about the service. Comments included, "XX often comments about the tasty meals, and snacks available." And "XX has put on weight since they have been here, which I am pleased about." One relative

Are services well-led?

commented, Staff are always friendly, caring and kind to residents and visitors." Another said, "Very happy with staff". A third said, "Thanks for the care given to XX, this takes a great deal of worry away from me."

One relative said, "Activities are inventive and fun." Another commented, "My relative's room is kept very clean; it is a treat to see. I am glad my relative is at this home, the other places I looked at were nowhere near as nice."

One person had commented that, "Any concerns I have had have been dealt with quickly and efficiently, I have no cause to complain."

One person had commented, "Clothes go missing and people are wearing other people's clothes." We saw that issues about the laundry and missing clothes had been dealt with through the complaints process, which demonstrated that the registered manager had used this feedback to improve the service.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision How the regulation was not being met: People who used services and others were not protected against the risks of inappropriate or unsafe care and treatment because the management team had failed to regularly assess and monitor the quality of the service. This was because they had failed to identify, assess and manage risks relating to the health, welfare and safety of people and others who may be at risk in relation to trends in relation to falls, and the management of infection control. Regulation 10 (1) (a) (b) and 10 (2) (i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control. How the regulation was not being met: People who use services and others were not protected against the risks associated with the exposure to healthcare associated infection .This was because systems designed to assess the risk of and to prevent, detect and control the spread of healthcare associated infection were not robustly being implemented. Regulation 12 (1) Regulation 12 (2)

Regulated activity	Regulation
	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and Suitability of Premises.

This section is primarily information for the provider

Compliance actions

How the regulation was not being met: People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because the management team had failed to take into consideration the layout and design of the premises in relation to the differing needs of people with or without dementia.

Regulation 15 (1) (a)

Regulated activity	Regulation
	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 How the regulation was not being met: People who use services and others were not protected against the risks of unsafe or inappropriate care and treatment because the management team had not taken steps to ensure that, at al times, the were sufficient numbers of staff employed at the service for the purpose of carrying on the regulated activity. Regulation 22