Care Quality Commission

Cotswold House Care Home Limited

Cotswold House 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?	Requires Improvement

Summary of findings

Overall summary

This inspection was completed on 4 and 10 July 2018 and was unannounced.

Cotswold House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Cotswold House accommodates 45 people in one adapted building. There were 29 people living at Cotswold House at the time of the inspection.

There was no registered manager in post at the service as the previous registered manager had left their post four months before the inspection. 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 of the Health and Social Care Act 2008 and associated Regulations about how the service is run. A new manager had started working at the service and was in the process of registering with the Care Quality Commission.

The previous inspection was completed in March 2017 and the service was rated 'Good' overall. At this inspection we found several concerns and the service was rated 'Requires Improvement' overall. During the inspection, the manager informed us about some of the measures they had implemented immediately to drive improvement. This included completing reviews of people's mental capacity assessments, reviews of people's care plans and arranging for further staff training.

Staff supported people to remains safe. However, risk assessments were not always reviewed and updated to ensure staff had up to date information about people's risk management plans. People received their medicines as prescribed. Improvements were needed to ensure medicine stocks would always be recorded accurately to prevent medicine errors occurring.

Staff had received training appropriate to their role. Although staff gave choice to people, the service was not always adhering to the principles of the Mental Capacity Act 2005 (MCA). People who lacked the mental capacity to make decisions about their care and treatment were not always supported to have maximum choice and control of their lives and staff might therefore not always support them in the least restrictive way possible.

Improvements were required to ensure people's care plans and associated documents were person centred and designed to meet their individual wishes, preferences and needs. In the absence of regular review of people's needs we could not be assured that the care people received was appropriately tailored to their needs for example, when they received end of life care.

The new manager had identified some of the shortfalls we found prior to the inspection. They had developed an action plan to address these concerns. However, the quality assurance systems had not always been effective in identifying and addressing shortfalls in relation to seeking consent from people and

risks related to the environment. In other cases, where action had been taken, this had not been sufficient to address concerns. For example, we looked at care plans which had been re-written to make them more person centred. However, we found these were either not up to date or lacked person centred information.

People, relatives and staff spoke positively about the manager. There was a positive culture in the service based on providing on care which was tailored to and met the individual needs of people. Where complaints had been raised, these had been managed appropriately.

Staff had received training around safeguarding and were confident to raise any concerns relating to potential abuse or neglect. There were sufficient numbers of staff working at Cotswold House. There was a robust recruitment process to ensure suitable staff were recruited.

People could choose what they liked to eat and drink and were supported on a regular basis to participate in meaningful activities. People we spoke with told us the staff were caring and kind. People were given information about the service in ways they wanted to and could understand.

This is the first time the service has been rated Requires Improvement.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff supported people to remains safe. However, risk assessments were not always reviewed and updated to ensure staff had up to date information about people's risk management plans.

People received their medicines as prescribed. Improvements were needed to ensure medicine stocks would always be recorded accurately to prevent medicine errors occurring.

Staff had received training around safeguarding and were confident to raise any concerns relating to potential abuse or neglect.

There were sufficient numbers of staff working at Cotswold House.

There was a robust recruitment process to ensure suitable staff were recruited. People told us they felt safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received training relevant to their role.

Staff did not have a good understanding of the Mental Capacity Act (MCA) and people who could not consent to their care did not always have their rights upheld.

People could choose what they liked to eat and drink.

Is the service caring?

Good

The service was caring.

People we spoke with told us the staff were caring and kind.

People were supported in an individualised way that encouraged them to be as independent as possible

People were given information about the service in ways they wanted to and could understand.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Improvements were required to ensure people's care plans and associated documents were person centred and clearly reflected their current level of need.

People were receiving end of life care. However, people's end of life care plans lacked detail and were not person centred

Where complaints had been raised, the concerns had been addressed appropriately.

People were supported on a regular basis to participate in meaningful activities.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Governance systems had been established in the service but these had not always been effective in addressing shortfalls.

There were positive comments from people, relatives and staff regarding the manager.

There was a positive culture in the service based on a strong desire to provide care which was tailored to and met the individual needs of people.

Care Quality Commission

Cotswold House 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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 4 and 10 July 2018 and was unannounced. Inspection site visit activity started on 4 July 2018 and ended on 10 July 2018. The inspection was completed by one adult social care inspector and an Expert by Experience (ExE). An ExE is a person who has personal experience of using or caring for someone who uses this type of care service.

We looked at the records of six people using the service. We spoke with the owner of the service, the manager and six members of care staff. We spoke with eight people living at Cotswold House. We spoke with five relatives who gave us feedback on the service provided at Cotswold House. We spoke with four health and social care professionals who have regular contact with the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe. One person said, "This is a nice place to be, I have a nice room and I am very safe." Another person said, "I haven't been here long, everything is very positive, I feel safe." Staff told us they were able to keep people safe. One staff member said, "I can raise any concerns with the manager. I am confident action will be taken quickly". The relatives we spoke with told us they felt their family member was safe at Cotswold House. One relative said "(Name of relative) is quite safe here, they take all precautions."

At this inspection we found that risks to people's health and wellbeing were being managed and people were receiving safe care and treatment. However, records relating to people's risk of skin damage did not always support this. For example, one person was at risk of developing pressure ulcers and their risk assessment stated they needed to be turned every two hours. As the two hourly turns had not always been recorded on their turn chart we discussed this with the manager and nurse. They told us the person's turn regime had been changed due to improvements in their skin condition but the risk assessment had not been updated. If this person was supported by staff who did not know them well, they were at risk of receiving care which was not in accordance with their current level of risk. For example, staff could injure the person whilst turning them when this was not necessary.

For some risks, management plans had been developed to ensure support staff knew how to support people safely and minimise any risks. For example, there were plans in place to minimise risks when people were at risk of falling. One person's falls risk assessment required a monthly review but we found that the risk assessment review had only been recorded twice in the past six months. Another person's mobility care plan stated they required support with hoisting and their moving and handling assessment should be consulted for details around this. However, there was no moving and handling record in their care file. We checked with the manager who told us they were unable to locate the assessment. We were satisfied that staff knew how to provide safe moving and handling support to this person. However,, if this person was supported by staff who did not know them well they were at risk of injury because staff did not have a care record to refer to informing them how to provide safe moving and handling support to this person.

People were supported with their medicines. There were clear policies and procedures in place on the safe handling and administration of medicines. Staff received training, observed other staff and completed a competency assessment, before being able to give medication independently. Care and support plans gave staff guidance on how people preferred to take their medication, which staff followed, to ensure they were meeting people's needs. People's medicine administration records (MAR) showed that people had received there medicines as prescribed. People's medicines were stored safely.

Records relating to people's available medicine stock were not always accurate. We found the medicine stock recorded on people's MAR did not correspond with the stock available. This was because medicines had been carried over from the previous month and had been added to the stock levels for the current month. When we discussed the inconsistency in stock levels with the nurse, they told us the medicine had been destroyed at the end of the previous month and had not been carried over. This had led to an incorrect recording of actual stock levels for the current month. In some cases, where medicine had been carried over

from the previous month, the stock levels had not been recorded. In other cases, we found medicines had been miscounted and incorrect stock levels had been recorded. This meant it was difficult for staff auditing the medicines to determine from people's MAR whether medicines had been administered and recorded safely.

The failure to maintain accurate and up to date records was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

Staff had received training on how to recognise abuse and how to report allegations and incidents of abuse. Policies and procedures were available to everyone who used the service. The manager and staff recognised their responsibilities and duty of care to raise safeguarding concerns when they suspected an incident or event that may constitute abuse. Agencies they notified included the local authority, CQC and the police. One staff member said, "If I have any concerns, I will raise these with the manager." Staff members told us about their confidence in the manager's ability to investigate and respond appropriately to safeguarding concerns. Staff told us they were confident to report any concerns to the local authority or CQC if they felt appropriate action was not taken by the manager.

The number of staff needed for each shift was calculated based on the number of people using the service and their presenting needs. People, staff and rotas confirmed there were sufficient numbers of staff on duty. The same staff were consistently used to ensure continuity for people who used the service. Throughout our inspection, we observed a strong staff presence in the service and staff were available at all times to support people.

New employees were appropriately checked through robust recruitment processes to ensure their suitability for the role. Records showed us staff had a Disclosure and Barring Service (DBS) check in place. A DBS check allows employers to see if an applicant has a police record for any convictions that may prevent them from working with vulnerable people.

Where people had been provided with equipment to support them, we found this had been maintained appropriately. For example, where hoists were used to support with moving and handling, these had been serviced regularly to ensure they were safe to use.

Staff completed training in infection control and food hygiene. This meant the chef could prepare meals as required and understood the procedures in place for minimising the risk of infections. Staff told us they had received appropriate training in their induction and this was useful. The home employed three housekeepers who covered the cleaning duties in the service seven days a week. The senior housekeeper told us the home had recruited a fourth housekeeper who would be starting shortly after the inspection. We found the service was clean and free from odour.

Requires Improvement

Is the service effective?

Our findings

The service provided was not always effective in meeting the needs of the people living at Cotswold House.

We viewed the training records for staff which confirmed staff received training on a range of subjects. Training included first aid, safeguarding, medication, Mental Capacity Act and DoLS (Deprivation of Liberty Safeguards). We saw that where staff training required renewing, staff had been booked to attend the relevant courses.

Staff we spoke with had limited knowledge of the MCA and their responsibilities in relation to Act. For example, they were unclear how they needed to assess people's level of capacity and were unclear on what a mental capacity assessment consisted of. This lack of understanding of the MCA was evident in the mental capacity assessments present in people's files.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible and legally authorised under the MCA.

We could not be satisfied that people's capacity assessments had been completed appropriately or that consent for care and treatment had always sought from people and documented in line with the requirements of the Mental Capacity Act, when required. For example, capacity assessments were not decision specific and covered a number of different areas in the same assessment. One person's capacity assessment covered their ability to make decisions regarding their environment and medicines within the same assessment. Another person's assessment had assessed a person's ability to make decisions about their personal care and nutritional needs within the same assessment. The MCA requires capacity assessments to be time and decision specific as people might have the capacity to make some decisions whilst being unable to make others. When decisions are assessed together there is a risk that every effort had not been made to encourage and support the person to make each separate decision themselves.

Where reviews of capacity assessments had taken place, we found these had not been recorded in the person's file. For example, one person's care file stated their mental capacity had been assessed three times in the past six months. However, we could not find the corresponding mental capacity assessments in the person's file to show why the service had come to the conclusion that capacity is either present or lacking for the particular decision.

Two of the care files we looked at had a consent form for care and treatment which had not been completed by the person or their representative. This meant it was not clear if the person had consented to receiving any care and treatment at the home.

Another person was being administered medicines covertly. This is when medicines are administered in a disguised format, for example in food or in a drink, without the knowledge or consent of the person receiving them. Covert medicine is considered when people refuse necessary medicines, it has been assessed that they lacked the capacity to make a decision about their medicines and a decision in their best interest had been made following consultation with their representatives and health professionals. There was no documentation to show whether this person had consented to taking their medicine this way or lacked the capacity to consent and therefore the best interest decision had been made during a telephone conversation with the person's GP to administer their medicines covertly. The person's care file stated that their GP had agreed to this verbally but had declined to confirm it in writing. There had been a failure from the service to assess the person's capacity and document thoroughly whether the decision to administer medicines covertly was in the best interests of the person and why this could not be confirmed in writing by their GP.

The service did not always work within the principles of the Mental Capacity Act 2005 (MCA) to assure people who lacked the mental capacity to make decisions about their care and treatment were supported to have maximum choice and control of their lives and that staff supported them in the least restrictive way possible. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for Consent.

We saw evidence that seven people had a DoLS authorisation in place and a further nine applications had been made to the authorising body. However, due to shortfalls relating to the assessment of mental capacity as detailed above, we could not be assured that a deprivation of liberty would always be identified and the relevant application made to the authorising body . The manager told us they would be reviewing the mental capacity assessments for everyone in the home to ensure a DoLS application was made if required.

The manager told us formal staff supervisions had not taken place in line with the provider's guidance that staff receive supervision at least every two months. This meant the manager could not effectively monitor staff performance or development. The lack of supervisions also meant the manager was unable to fully assess the effectiveness of staff training and identify further learning needs for staff. Although, supervisions had lapsed, staff told us they were well supported by the manager. The manager had also developed a plan to ensure all staff received regular supervision.

Staff had completed an induction when they first started working in the home. This included reading policies and procedures, completing core training such as first aid and safeguarding and undertaking shadow shifts. These shifts allowed a new member of staff to work alongside more experienced staff so they felt more confident working with people. This also enabled them to get to know the person and the person to get to know them. Staff told us they had found the shadow shifts a "good learning experience". The manager told us new staff would also be supported by a senior member of staff who they could approach if they had any questions or concerns. Staff told us they had found the mentoring experience to be positive and it gave them confidence there was somebody always available if they had questions during their induction.

People were supported to ensure they had sufficient food and drink. People spoke positively about the food provided at the service. One person said, "Lovely food, it's always good". Another person said, "Food is very good, it's like a top-class restaurant." People told us there was always a choice of meals and if they wanted something different to what was being served the chef would provide an alternative meal option. The relatives we spoke with told us they felt the food provided at the service was of good quality. The manager told us the menu was always under review so that they could provide meals which met people's

preferences.

People's care records showed relevant health and social care professionals were involved with people's care. This included GPs, dentists, opticians and specific health professionals such as occupational therapists and cancer specialist nurses. In each care and support plan, support needs were clearly recorded for staff to follow about attending appointments and specific information for keeping healthy.

The building and gardens were well decorated and maintained to a good standard. There was a warm, welcoming and homely atmosphere at Cotswold House. People were supported to decorate their bedroom to their individual preferences. People and their relatives confirmed they could choose how their rooms were decorated. Access ways had been adapted to make them accessible to wheelchair users. As the service was provided over three floors, there was a lift to enable people to access all areas of the home.

Good

Is the service caring?

Our findings

The service provided to people was caring. People were supported by staff who were kind, compassionate and caring.

There were positive comments about the staff from people, their relatives and health professionals. One person said, "Staff are more than kind, they go out of their way to do everything to suit me." One relative we spoke with said, "Staff are very friendly and caring, I have no worries or concerns."

There were many compliments evidenced in a large file with letters, emails and cards. One person had written, "Thank you all so much for the love, care and attention that you gave to (name of person) during her time with you. We shall never forget the warmth and friendship that we as a family received." Another person had written, "To all the staff at Cotswold Care. Words cannot express how grateful we are to you all." One member of staff told us the positive feedback was appreciated by the staff team as it recognised the good work they were doing.

During the inspection, we observed various incidents of staff supporting people with dignity and respect. For example, on the first day of the inspection, one person was displaying inappropriate behaviour in the lounge area. The member of staff supporting them supported them to leave the communal area but ensured they maintained the person's privacy and dignity at all times through their kind and caring approach.

People were supported by a consistent team of staff. This ensured continuity and enabled people to get to know the staff who supported them. People told us the consistent staff teams were reassuring for them as they were confident they would be supported by familiar staff who knew them well. The manager told us about their 'whole home' approach at lunchtime so that they could all build positive relationship with people and get to know people better. The manager explained all the staff at the home regardless of job role would support people during lunch. The staff we spoke with told us this allowed all the staff to get to know people better and build stronger relationships with people. One member of staff said, "I am a housekeeper and this has really allowed me to get to know the people. Because I know so much about people, I can have meaningful conversations with them whilst I am cleaning their room or other parts of the home."

People's care records included an assessment of their needs in relation to equality and diversity. Staff we spoke with understood their role in ensuring people's needs were met in this area. Where people indicated a preference, they were supported to access activities in relation to their religious or cultural background. All the people we spoke with told us that staff treated them with dignity and respect, particularly when they were delivering personal care. People told us how staff would respond quickly to any concerns they have. One person said, "If I use my call bell they always come quickly."

The manager told us people's privacy was taken seriously and all staff were required to maintain confidentiality at all times. Where records were kept on paper, we saw that these were stored securely in locked drawers and offices. Other records which were kept on computer required a username and password for access.

The manager told us family and friends of people living in at Cotswold House could visit at any time. People and their relatives confirmed that there were no restrictions on visiting. One relative commented on how they could visit their family member as much as they wanted and there were never any restrictions on when they could visit.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive to people's individual needs.

Each person had a care and support plan to record and review information about them. The care and support plans detailed individual needs and how staff were to support people. Each care and support plan covered areas such as; safety, personality, physical health, eating and drinking, environment, family, friends and community, biography, sensory impairment and spirituality. On the front page of people's care and support plans their likes, dislikes, critical care and support needs were documented. A preferred routine was available to show how people liked things to be done. One person's care and support plan stated how their personal care should be carried out, what food or drinks they liked and any other tasks that need to be completed.

However, the system to record and review people's care needs and preferences was not always effective. The manager told us each person's care plan should be reviewed every month as a minimum and more frequently if their needs changed to ensure that the service would have up to date information about people's care needs and preferences. However, we found this was not happening. For example, one person's care plans had been reviewed once in four months. The person's care plan stated they required support to access the toilet every three hours to keep their skin healthy and this should be recorded. We could find no record of the support the person had received to access the toilet. We discussed this with the manager and nurse who told us the person's needs had changed and they no longer required this support. In the absence of regular review of people's needs we could not be assured that the care people received was appropriately tailored to their needs.

The service was providing end of life care to people. Although each person had an end of life care plan in their care file, we found this was not person centred and lacked detail. For example, one person's end of life care plan stated they had a DNAR (Do not attempt resuscitation) form and no other details of the care to be provided. Another person had been admitted to the service and was receiving palliative care. Their end of life care plan did not contain any preferences from the person or input from their family to inform the person's care at the end of their life. The end of life care plan stated, 'nursing staff to monitor and manage symptom relief and pain'. However, there was no information about the actual symptoms or how they would be managed. The person had specific equipment to administer their pain medication but this had not been recorded in their end of life care plan. Without clearly written guidance, staff were not in a position to provide individualised support in a consistent way that recognised their specific needs. While staff who had worked at the home for some time were familiar with this person's needs, staff new to the home would be reliant upon the information they received verbally from staff.

We discussed the service's end of life care planning with a health professional who has worked with the service in relation to end of life care. They told us that the service was not always adequately prepared to response promptly when people were admitted to the service at short notice requiring end of life care. For example, they told us one person had been admitted to the service for end of life care and required a syringe driver. A syringe driver is a small battery-powered pump that delivers medication at a constant rate through

a very fine needle under the skin. However, when the person had been admitted to the service, it was disclosed to the community nursing staff that there were no nurses in the service who had had their competencies assessed and subsequently approved to use a syringe driver. This meant the person's needs in relation to this could not be met by staff in the home until they had received the appropriate training.

Failure to provide a care and support plan designed to achieve people's preferences, including their wishes and ensure their individual and specific needs are met is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported on a regular basis to participate in meaningful activities. There was a full-time activities coordinator employed at the home. There was a full and varied activities programme, and close links with the community, including a local school and other care homes. At the time of the inspection, the home was trialling an increased offering of exercise such as arm chair yoga, tai chi and seated ballet. The manager and owner told us this was done with a view to identifying if this may reduce the number of falls in the home. The home had also implemented mind focused activities, prior to lunch, with the aim of stimulating the mind before lunch time. The manager told us they found that this often had a positive impact on people's appetites and they had seen a trend in the home of people eating bigger portions with their weights increasing.

During the inspection we observed daily activities in the mornings and afternoons. It was evident that staff involved all the people in the communal area if they indicated a wish to participate in activities. All the people we spoke with praised the activities coordinator for the effort they put into their role and the variety of activities on offer. Relatives we spoke with praised the activities coordinator for their enthusiasm and dedication.

There was a complaints policy in place which detailed a procedure for managing complaints. Where complaints had been made, there was evidence that the concerns raised had been addressed. The people we spoke with told us they could raise any issues and these would be addressed. Relatives told us they had confidence in the manager and owner to fully investigate and respond to concerns raised by people or their families.

Requires Improvement

Is the service well-led?

Our findings

The service was not always well-led.

There was no registered manager in post during our inspection as the previously registered manager had left their post in February 2018. A new manager had been recruited and had commenced employment in February 2018. They were in the process of registering with CQC to become the registered manager to support the provider to meet the requirements of their registration and had submitted their application for this.

People and staff were complementary about the manager. People, their relatives and staff told us the manager was a good leader and was approachable. Staff told us they had a good relationship with the manager and they felt listened to. One staff member said, "The manager is always around and helps us in our daily role."

The manager told us they held responsibility for the day to day management of staff and people's care. The manager told us that the provider was supportive and available if any practical issues for example, relating to the premises was to arise.

Systems were in place for the provider, manager and staff to assess, monitor and mitigate risks to people's health and safety. The manager through audits of the service had identified some areas of improvement and had developed an improvement plan to address the concerns. For example, the manager had developed a supervision plan to ensure all the staff within the home received regular supervision. The manager was working in partnership with other stakeholders to improve areas of the service. For example, they were liaising with the local Care Home Support Team and local authority to arrange for further training for staff. This included training around the Mental Capacity Act and record keeping. The manager and provider listened to our feedback at the end of the inspection and told us they will also be arranging end of life care training for the staff.

However, the action taken had not always been sufficient to address the shortfalls identified. For example, Care plans and risk assessments were in place but were not always reviewed and updated to reflect people's changing needs. Where care files had been reviewed, we found these still contained information which was either missing or inaccurate. For example, one medicines care plan recorded that they were always administered their medicine covertly. However, this was not always the case as the manager told us the person would at times take their medicine when prompted and staff were always required to prompt the person in the first instance. Care plans audits had failed to always identify when people lacked capacity to consent to their care that staff had not followed the requirements of the law to protect people's rights. For example, one person was at times being administered medicines covertly but their capacity had not been assessed.

In other cases, the audits had not always been carried out at their required frequency. For example, audits of the home environment had been completed twice in the past six months. This meant that environmental

risks could not always be address in a timely manner. For example, we observed an open hoist outside people's rooms in the corridor. The legs of the hoist had been left open posing a trip hazard to people. Where fans were being used to cool the corridors, we found trailing wires which posed trip hazards to people in the corridors. Although immediate action was taken when we discussed this with the manager, the risks had not been initially identified by the manager or staff.

An effective system was not in place to ensure staff training, observation of their practice and supervision would always be completed on time. This meant gaps in staff's knowledge had not always been identified and plans but in place to minimise the risk of people receiving inappropriate care. For example, no competency checks had been completed to ensure staff fully understood the principles of the MCA or learning from other training which they attended. The staff we spoke with lacked confidence to implement the provider's decision-making policies when people lacked mental capacity. The manager told us staff had not received supervision in line with the provider's guidance that staff receive supervision at least every two months. The manager told us staff training was an area that required further enhancement and she was committed to improving this.

The failure to provide good governance to ensure the safety and quality of service provision is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was actively seeking the views of people, their relatives and the staff through sending out questionnaires and having regular meetings. The provider and manager told us this was a way of ensuring everyone involved with the service had a voice. The provider and manager had analysed the feedback from the surveys sent out and had incorporated areas for improvement into their improvement plan for the service.

Regular resident and staff team meetings were held and records kept. Staff told us they found these meetings useful. We saw from the minutes of the meetings that staff were encouraged to express their views and opinions and any concerns or issues raised were responded to.

There was a positive culture amongst the staff working at Cotswold House. Staff commented that morale had improved since the current manager started in their post. One member of staff said, "The was a lot of uncertainty and changes when (name of manager) started but things have improved massively. We are a much happier staff group now." Another member of staff said, "(Name of manager) is approachable and one of the team. She is great for the team." Staff told us they were all focused on providing good quality care to people which met their individual needs. The manager and owner acknowledged that improvements were required but reassured us they were committed to implementing positive changes to improve the quality of service provided to people.

From looking at the accident and incident reports, we found the manager was reporting to CQC appropriately. The provider has a legal duty to report certain events that affect the well-being of the person or affects the whole service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care There had been a failure to provide a care and support plan designed to achieve people's preferences, including their wishes and ensure their individual and specific needs are met. 9(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent for care and treatment had not always been sought in line with the requirements of the Mental Capacity Act 2005. 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There had been a failure to assess, monitor and improve the quality and safety of the service. 17 (2)(a) There had been a failure to maintain an accurate, complete and contemporaneous record in respect of each service user. 17 (2)(c)