







# The Disabilities Trust Shinewater Court

## Inspection report

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Date of inspection visit: 16 June 2015  
Date of publication: 28/09/2015

### Ratings

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

### Overall summary

Shinewater Court is part of the Disabilities Trust, a charity set up to support people with disabilities, and provides accommodation and support with personal care for up to 36 people with physical disabilities. There were 34 people living in the home during the inspection, some people needed assistance with all aspects of their daily living, including personal care, eating and drinking and moving around the home. Other people needed assistance with personal care and were able to move around the home independently.

The home was purpose built, with wide corridors and automatic doors, and a lift for access to some of the flats. There was easy access for people to all parts of the home, the gardens and local community areas.

The inspection took place on 16 June 2015 and was unannounced.

The home was run by a registered manager who was present during the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

# Summary of findings

providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were not always enough staff to meet people's needs and a system to determine appropriate staffing levels was not in place. People said they had to wait for assistance and some people were unable to participate in activities of their choice.

The care plans, including risk assessments, did not record people's needs accurately. Daily records did not reflect how people spent their time or how staff supported them to be independent.

The provider had quality assurance systems in place to audit the services provided at the home, but these did not address areas for improvement identified by the management.

People's opinions of the food varied. Some people were very complementary, while others wanted changes made to the meal times and the choices available.

There were systems in place to manage medicines, including risk assessments for people to manage their own medicines. Medicines were administered safely and administration records were up to date.

Staff had attended safeguarding training and a safeguarding policy was in place. They had an

understanding of abuse and how to raise concerns if they had any. Staff showed an understanding of their responsibilities and processes of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

Activities were available, in the activity day room or other parts of the home, for people to participate in and some people preferred to remain in their rooms.

Complaints procedures were in place. People said they knew about the complaints procedure and when they raised concerns these had been addressed.

The registered manager told us the home operated an open door policy and encouraged people to be involved in discussions about the support provided. People agreed with this and said they could talk to the registered manager and staff at any time.

Monthly residents meetings, quarterly staff meetings and joint meetings enabled people and staff to raise any concerns or make suggestions for improvements to the support provided. People and staff felt confident their views would be listened to although any improvements or changes seemed to take a long time to introduce. Communication between people and staff was open and relaxed, and areas of concern were discussed openly. Including the staffing levels and areas where savings could be made.

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?

The service was not consistently safe.

There were not enough staff working in the home to provide adequate support for people.

Medicines were administered safely and records were up to date.

Staff had attended safeguarding training and had an understanding of abuse and how to protect people.

Recruitment procedures were in place to ensure only suitable people worked at the home.

**Requires improvement**



### Is the service effective?

The service was not consistently effective.

People were supported to maintain a healthy diet, but people's preferences were not always met.

Staff were trained and supported to deliver care effectively.

Staff had an understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Staff ensured people had access to healthcare professionals when they needed it.

**Requires improvement**



### Is the service caring?

The service was not consistently caring.

People were treated with kindness and respect.

Staff encouraged people to make their own decisions about their care.

People were encouraged to maintain relationships with relatives and friends, and relatives were made to feel very welcome.

**Requires improvement**



### Is the service responsive?

The service was not consistently responsive.

The care plans were not specific to each person's needs and there was no clear guidance for staff to follow when providing support.

People decided how they spent their time; some people were supported to take part in activities, whilst others remained in their rooms.

People were given information how to raise concerns or make a complaint

**Requires improvement**



# Summary of findings

## Is the service well-led?

The service was not consistently well-led.

A registered manager was in place, who had a good understanding of the improvements that were needed, but they were slow to happen.

Quality assurance audits were carried by the provider, but it was not clear if these had improved the service, in a timely manner.

People met regularly to discuss the services provided and felt involved in decisions about the home and the support they received.

Staff felt able to discuss the support and care provided with each other and the registered manager, and were encouraged to put forward improvements to the service.

**Requires improvement**



# Shinewater Court

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

The inspection took place on the 16 June 2015 and was unannounced. The inspection team consisted of an inspector, a pharmacy inspector and an occupational therapist.

Before our inspection we reviewed the information we held about the home, including the Provider Information Return (PIR). This is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make.

We looked at information provided by the local authority, contracts and purchasing (quality monitoring team). We also looked at information we hold about the service including previous reports, notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law.

As part of the inspection we spoke with 12 of the people living in the home, two relatives, eight staff, the physiotherapist, the cook, assistant manager and registered manager. We observed staff supporting people and reviewed documents; we looked at six care plans, medication records, two staff files, training information and some policies and procedures in relation to the running of the home.

# Is the service safe?

## Our findings

People told us they felt safe living in the home. One person said, “I feel very safe here, staff are very good, they have a lot to put up with. I can lock my own door and the exterior doors are locked at night.” Another person said if they felt unsafe they would, “Pick up the phone and call my case manager (social services).” All of the people we spoke with said there were not enough staff working in the home. They told us, “It is bad at weekends.” “It’s difficult to find time they are busy, the staff always running round. Why not get more staff to come and work here” and, “When staff leave it is difficult to recruit them.” Some of the staff felt they did not always have the time to provide the support people wanted.

There were not enough staff to provide appropriate support and meet some people’s needs. People and staff said there was not enough time for staff to provide one to one support for some people. One person said, “We have to wait sometimes, which is ok, but sometimes we are not up until lunchtime, which means half the day is gone.” People waited for support at mealtimes and there were not enough staff to enable people to sit and have their lunch together. We saw one member of staff assisting two people with their lunch at the same time; one of the people supported said, “I hate feeding with two because I feel sometimes it’s slow, and with one to one I would have more interaction.” They said the food was often went cold while staff were assisting them to eat.

Staff told us they did not have the time to support people to take part in activities of their choice. Some people needed support to set up an activity and then work through the activity, which meant the staff were not available to support other people. The activity day centre was full and the two staff were moving from one person to another setting up computers and assisting. Some people said they had enough to do but others felt they wanted more. However, the activity staff were at full stretch and could not give one to one for very long to any one person. Most of the residents were wheelchair users and some had limited or no verbal communication therefore some people needed a lot of assistance. One person told us the low staffing level meant they did not have enough time to use

their word board to communicate with staff. Another person liked to go swimming. They said they had not been for a long time because there were not enough staff to go with them.

The PIR clearly stated there would be minimum levels of staffing. There was no evidence that the provider used a specific system to calculate these levels, or that they were linked to meeting people’s individual needs. Feedback from people completing the provider’s survey regarding mealtimes identified the lack of staff as a concern in March 2015 and the PIR recorded that people’s relatives had informed the staff and management there were not enough staff working in the home. The registered manager told us there had been discussions about staffing levels with the provider, and they had been reviewing ways of re-arranging the staff allocations throughout the day to ensure there were enough staff at peak times. Such as in the morning and evenings, when people want to get up and go to bed, at meal times and at the weekends. There were no cleaning staff at weekends. This meant care staff had to do some cleaning rather than spending time supporting people. The registered manager sent us a graphical picture of the staffing levels and there are clearly more staff in the home at peak times, but there was no evidence that the allocation of staff was appropriate to meet people’s needs during the inspection.

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

The paving slabs in the internal garden area were uneven and there were gaps in between some, the wheels of self-propelled wheelchairs could go into these. This meant people were at risk because the chairs may fall over or they may get stuck and people would have to wait for staff to assist them. One person said the pathways were a problem and one staff member told us they did not know if they were going to be repaired. There was no information about this in the minutes of the meeting where improvements to the building were discussed. The focus of the modernisation program was on the reception/dining area/ activities centre/ updating bathrooms/ changing fire doors/ corridors, but not the garden areas.

Risk assessments had been completed in the care plans we viewed; they were similar for each person, such as medication and finances, although people’s needs differed, which meant appropriate guidance for staff may not be

## Is the service safe?

available. For example, one person needed two staff to use the ceiling hoist when they transferred them to and from the bed. However, when staff assisted the person to move in bed they said that staff did not always follow the correct procedure. The person had to remind staff when this occurred. The information recorded in the care plan did not identify this person's specific needs. The registered manager said they were reviewing the care planning system, including the risk assessments, and they were concentrating on making them specific to each person.

Systems were in place to manage people's prescribed medicines. Several residents managed their own medicine and this self-administration was against a documented risk assessment. People we spoke with told us they had not encountered any problems with managing their own medicines. Other people were supported with their medicines and they told us that they were happy with how this was managed.

Care plans contained guidance for staff to manage people's medicines when it was prescribed to be taken only as required (PRN), and audits of medicine use were conducted. Training records showed that staff received yearly training and monthly competency checks. Systems were in place to report and address any mishaps or errors with medicines. Corrective and reflective action was taken and staff involved were taken off administering medicines, until they had completed further training, and were assessed as competent to handle medicines. We were told staff on duty must be trained and competent in the administration of all types of medicine, including those administered using a special technique, such as Midazolam for epilepsy. Staff on duty during the inspection had not been trained to give this medicine and they managed this by calling out an ambulance. The registered manager said they had clear systems in place to ensure people were safe if the staff available were not qualified to administer these medicines and additional training had been arranged to ensure sufficient staff would be available on each shift. This was supported by the training record.

We found that people were as far as possible protected from abuse. Staff had a good understanding of how to protect people and all staff had attended training. Staff were aware of different types of abuse and said if they had any concerns they would report them to the team leaders

or registered manager. Staff said they had read the safeguarding and whistleblowing policies and were confident they would follow them if they had any concerns. Staff told us they had not seen anything they were concerned about and felt people were safe. One staff member said, "We work well as a team and keep people safe, whilst not restricting them." Staff were aware that if they had concerns, and the registered manager or provider did not take action, they could contact the local authority or Care Quality Commission (CQC). The registered manager said they were aware of the Sussex Multi-agency safeguarding procedures and these were available to refer to. They told us the local authority had investigated a safeguarding issue. They had taken action to ensure the concern would not be repeated, through staff training and a review of their procedures regarding admissions to hospital from the home. There was written evidence to support this.

Recruitment procedures were in place to ensure that only people suitable worked at the home. We looked at personnel files for two new staff; they included completed application forms, two references, confirmation from the Disclosure and Barring Service that prospective employees were safe to work with people, interview records and evidence of their residence in the UK.

The provider had a plan to deal with an emergency. The registered manager explained how people would be assisted to leave the building, all rooms had access to ground floor level, and most people could leave the building from their own rooms, as they had direct access to the internal garden. They had identified people who did not have this access and the plan stated how these people could be assisted to move to a safe area.

Incidents and accidents were recorded. The records showed information about the incident, the action taken by staff and how they were to prevent a reoccurrence. One staff member said they assessed any incidents so they could understand why they occurred to make sure they were not repeated. For example, there was a concern that one staff was using a hoist to assist someone and there should have been two staff. This was referred to the local authority under safeguarding, additional training had been provided for all staff and staff allocations ensured two staff supported this person.



# Is the service effective?

## Our findings

People had different views of the food provided. Some people thought it was very good, they were very complementary and they liked the choices; other people said the food was often cold and it would be better if their meals could be cut up when first given out at the counter rather than waiting for staff to do this later. One person said, “The food is horrible and bland and cold, I like a bit of colour and flavour, it’s not tasty.” Another person said, “The food is very good, I like the choices most of the time.” Comments from relatives in the PIR stated that staff did not support people appropriately at mealtimes.

People’s choices were limited to fit in with the routines of the home rather than make choices about their mealtimes. People’s responses in the mealtime survey, devised by one of the people living in the home, identified a number of areas some people wanted changes made. Such as the mealtimes, which were between 12–1pm for lunch and 5–6pm for supper. There did not seem to be any flexibility to suit people’s preferences, such as people having meals in their rooms. Individual comments included, “I would like supper later, not a pre-plated sandwich though. From 6pm until I go to bed is a long time since food.” An action identified from the survey was to set up a ‘meeting with a committee made up of people and management to discuss how supper can be extended to later into the evening’. It was not clear why people were unable to choose when they had their meals and the registered manager said this was part of the issues around meals that were still being discussed and no decisions had been made.

People’s preferences and choices with regard to meals were not always taken into account when planning and providing food. There were two main choices at lunchtime, with other options if people did not want what was available. One person liked to have salads and told us there were none available at weekends. The registered manager said she did not know salads were only available on weekdays. Two people told us their meals were cold. There was no way to keep meals warm while people were eating, particularly for people who may take some time to eat their meals, and no action had been taken to address this. Staff said a hot plate was on order to keep the food hotter. However, this would not address keeping meals warm during the meals. Several people were very positive about

the food, they felt they had plenty of choices and liked the options available. One person said, “We can have what we want really, there is usually two main meals and we can have something different if we like.”

Staff said the training was good. One new staff member said, “I am shadowing all the time at the moment, working with experienced staff to look after male residents only.” All new staff completed induction training in line with skills for care, including fundamental training, such as safeguarding, moving and handling, infection control and fire safety. We spoke with two new staff and they said they learnt a lot from the staff they worked with. One of them said, “It will take us some time to understand everyone’s needs, and the staff are very supportive. We want to make sure people live the best life they can and make their own decisions.” A staff member told us, “We are told if our training needs to be updated and we have to attend, which is a good way of doing things.” All of the staff said they enjoyed working at Shinewater Court and felt they could support people. One staff member said, “I love working here, I wouldn’t work anywhere else.”

Staff also said they could work towards professional qualifications if they wanted to, and three staff said they had completed National Vocational Qualifications (NVQ) in Care to Level 2 or 3. Staff said they knew what their responsibilities were and felt supported by the management to provide good care and support for people.

A supervision programme was in place. Staff told us they had had one to one supervision and they felt this gave them chance to sit down and talk about anything, and find out if there were areas where their practice could improve. The registered manager said they had introduced team leaders who were responsible for supporting people on their shift and the supervision of a group of staff. One team leader told us there was usually a team leader on each shift and they would oversee staff to ensure people were supported to be independent and decide how they spent their time. They felt staff offered good support and care and they were positive about comments made about their work on a day to day basis or during supervision. They said, “We work very well together, we have our own areas of responsibility and know how best to support people and each other, so that we can provide good support.”

Two members of the staff told us they had attended training in Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Discussions had taken place with the



## Is the service effective?

local authority regarding people's capacity to make decisions and the agreement was that people were able to make decisions about all aspects of the support provided. Applications had been made. Staff said they asked for people's consent before they offered care and support and respected people's choices. We saw staff asking people where they wanted to sit at lunchtime, if they wanted to join in activities and they asked if people wanted to return to their rooms after lunch.

People had access to healthcare professionals including opticians, district nurses and GPs as required. GPs visited

the home if necessary and the visits were recorded in the care plans with information about any changes in support. An occupational therapist and physiotherapist provided support at the home. People were very positive about the support they provided. One person was using an adapted bike, which meant they could use the bike although they had lower-limb mobility impairment. They told us they were enjoying using the bike, "Very much." Another person used a stand aid in their room to build up muscles with the physiotherapist and felt, "Really good" as they had been able to stand up for 17 minutes.

# Is the service caring?

## Our findings

People were positive about the care and support they received. They said, “Staff are better here than in my previous home.” “It’s like a family here”. “I have a nice key worker, I can talk to her, I see her once a fortnight, it’s not enough.” “It’s the best place in the world.” “I am very happy here, I have a keyworker.” “I have no pressure sores the carers check every morning and at night.” A relative said their family member now had a, “Key worker who has a good attitude and talks to them.”

People and staff talked about how they were going to spend their day, as part of everyday conversation, and the interaction was relaxed and friendly. We saw staff demonstrating compassion and good listening skills when one person was upset. People were relaxed and comfortable sitting in the lounge watching TV, in the garden or in their own rooms. Staff put forward suggestions about what people might like to do, but respected people’s choices if they decided not to join in or do something else. Staff said they always asked people if they needed assistance, they never made decisions for them and they respected people’s choices. One person was supported to dress a particular way; another person liked to sunbathe in the garden and staff supported them by applying suntan lotion to protect their skin. People said they made decisions about the support provided and felt staff responded to their requests, “As soon as they could”. One staff member said, “We like to make sure that they decide what they want to do and keep their independence.”

People felt that their privacy and dignity was respected. Staff said they always knocked on people’s bedroom doors before they entered, and people confirmed this. One person said, “Staff knock and call my name to check that

they can come in before they do”. Staff treated people with respect and protected people’s dignity when asking them discreetly if they needed assistance with using the facilities. Staff said they offered people support with their personal care when people wanted it and asked their permission to assist them to move around the home.

The home was purpose built to accommodate people with physical disabilities who used wheelchairs. The corridors were wide, doors opened automatically and people’s rooms were well furnished. People had personalised their rooms and there was separate wardrobe space in the bedrooms, and a separate bathroom, kitchen and lounge in the flats. People were kept informed about any changes to the home, and the support provided, through meetings and minutes of these meeting were available for people and staff to read. One person said, “There are going to be some improvements, but we don’t know when”. Staff told us the provider was planning to refurbish most of the home, including new carpets and re-decoration. However, these were still under discussion with the Trust and there was no timescale for the completion of the improvements.

The registered manager said advocates could be arranged for people if they wanted this support. People told us they did not need advocates. One person told us, “They are available, but we don’t need them.”

Relatives and friends were welcomed into the home and people were encouraged to maintain relationships with people close to them. People said their relatives could visit when they wanted and relatives told us the staff were always pleased to see them, and they were made to feel very welcome. A relative said they visited the home regularly, they brought their dogs for their family member to see and other people also enjoyed these visits.

# Is the service responsive?

## Our findings

People felt involved in planning the support they received and felt that staff respected their wishes. One person said, “They are a really good lot of staff, they are a bit busy to do everything when people want it but it isn’t their fault. There just are not enough of them.” People were asked if they had a preference for male or female staff to support them; this was recorded in their care plans and staff were aware if people had a preference. One person said, “I did my own care plan with the manager. I have a new key worker just recently. I feel listened to.” Staff told us the care plans were kept in some people’s rooms, so they could refer to them if they needed to. Some people had asked for their care plans to be removed from their rooms, because they did not want visitors to the home to read them, and staff respected their choice. People said the activities were very good; they had a range of choices and could choose what they wanted to do. People told us, “If we want to do something different we ask and see.” “I like the garden club, I go to art classes and computer, it’s enough” and, “I am in the choir and last week we did the Sound of Music in the lounge.”

The care plans lacked specific guidance for staff to follow, which meant that people’s needs may not be met. There was no information about how people communicated their needs when they were unable to communicate verbally. Staff did not know why this information was not included in the care plans. New staff said they read the care plans during the first few weeks so they had an understanding of people’s needs. However, the information was not correct and did not include people’s individual needs; therefore new staff may not have a clear understanding of people support needs and how these could be met. The registered manager said the care plans needed to be reviewed and updated and they had made some changes in some care plans. They said the aim was to involve people in developing the care plans and this would take some time, depending on each person’s needs.

Staff told us they were kept up to date with regard to people’s needs through handovers at the beginning of each shift. They felt they had a good understanding of how people’s needs changed day by day and how they should respond to make sure the person received the support they needed. Staff said they recorded this in the daily records. However, we found there was very little information in

these records and there were large gaps. One record stated the time the person had got up, washed and had breakfast was between 10.45 and 11.45. The next record was at 9.30pm when they person was going to bed. There was no record of how the person had spent their day. The person told us how they had spent their time; they had been assisted to get up late, had lunch and spent time on their computer. The daily records did not evidence the support provided by staff, that people’s needs had been met or that people had been supported to spend their time as they wished.

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

People’s profiles, with information about how they liked to spend their time and their interests; what was important to them such as friends and family was included in the care plan. There was information about people’s support needs, including moving and handling, positioning in bed, their preferred time to get up and go to bed and have their meals. People who preferred to stay in their rooms or spend time on their own were supported to do so. The registered manager demonstrated a good understanding of people’s needs and was aware of where people spent their time, particularly if they chose to be on their own, to ensure they did not become isolated. We saw people interacted with each other when they chose to do so. Staff knew which people liked to sit together at mealtimes, the activities people enjoyed and the support they needed to take part in activities they enjoyed, such as gardening and staff assisted people so they could participate. The activity person told us they had discussed the need for more IT support with people who used communication systems. People used EZ keys and eyegaze programmes on the computers to communicate when they are unable to do so verbally in the activity room, and some people used ipads. They had arranged for an IT expert to visit weekly to keep people and staff abreast of new IT programmed and hardware.

A range of activities were available for people to participate in if they wished. Staff said people sometimes saved up their one to one time, so they could do something that takes longer than the time allocated, such as saving up four hours so they could go out into the community. People attended college during term time and the college provided courses at the home on Mondays. The courses

## Is the service responsive?

included food preparation, pottery, music, outings, art and pet pals, computers, gardening, flower arranging and crafts. Eleven people were working through Focus workbooks, which offer 12 separate subjects including communication, using computer technology and horticulture. People were supported to attend Combat Days, which involved archery and fishing, and some people went on regular outings such as disability sailing, Airbourne, garden centres and ten pin bowling. People were also supported to attend church services. This meant the activities were flexible and people were able to make some choices about how they spent their time outside the home.

There was some evidence that the registered manager and staff responded to requests or complaints that people made. Such as ensuring one person had their medication at 10am rather than at any time between 10 – 11am

window. Arranging for the maintenance person to change the temperature of the hot water in a person's room and organising visits from relatives who live some distance from the home for another person.

A complaints procedure was in place; a copy of this was displayed in the entrance hall, and given to people and their relatives. Staff told us if there were any issues they tried to deal with them at the time, such as 'niggles between people', or complaints about the food. People told us if they had any complaints they talked to the staff or the registered manager, they were confident they were listened to. They said things, "Usually got sorted out," when they asked for something and staff were always looking at ways to improve the support they received. Relatives said they did not have any complaints, but if they did they would talk to the registered manager, although they felt people would address any issues themselves most of the time.

# Is the service well-led?

## Our findings

The culture at the home was open and relaxed. The registered manager said people, staff and visitors were encouraged to contribute and make comments or suggestions about how the support might be improved. The home had a calm community atmosphere. People assisted each other, and waited patiently and with good humour, for other wheelchair users to pass them. Staff demonstrated the same courtesy and we saw staff smiling and talking to people. The registered manager said, "People are involved in all the decisions we make about the home and the support provided, and they are encouraged to comment on what is happening, or not." People felt the home was well led and said, "The manager is alright. A good girl." "The manager has been marvellous, very supportive, since she has been here" and, "It's the best place in the world." A relative told us, "The home has significantly changed for the better lately." Staff told us, "The trust are very good here. The manager has been marvellous, very supportive. I feel that I am kept informed".

Shinewater Court is part of The Disabilities Trust, a charity set up to provide support for people with disabilities. People and staff said this had been a difficult time for everyone, because of the changes in leadership. One staff member said, "We weren't really sure what was going to happen." The registered manager had been in place since December 2014 and was not planning to remain managing the service, the manager's post had been advertised.

They discussed openly the areas where improvements were needed, and changes that had already been made to ensure people were safe. Such as the ordering, receipt, storage and administration of medicines following a visit from the quality monitoring team of the local authority. The PIR stated there were regular visits from the Trust's quality team to review different aspects of the service monthly. The registered manager said they worked together to make sure all aspects of the support provided was what people needed and wanted, and that they met the requirements of the placing authorities and the Care Quality Commission (CQC). However, it was not clear how the necessary improvements in staffing, record keeping, including care plans, had been, or would be, addressed. These issues had

been ongoing for several months, and there was no evidence that action plans with a timetable and dates when the changes would be completed, were used by management to review any changes.

The lack of effective quality assurance and monitoring was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff said the registered manager was always available, checking that things were as they should be and making sure people had what they wanted. We inspected the home, people greeted her warmly and she had something to say to each person we were introduced to. She managed a difficult situation where two residents did not see eye to eye. She calmly and respectfully listened to the issues of one person even though the person was not sure if they had already told her of the difficulty.

People and staff were very positive about the meetings for service users and staff, combined and separately, they felt the management were quite open and they could have they say, but also felt there had not been many changes or improvements despite the discussions. Residents meetings were held monthly and were well attended. Meals in terms of waste, menus and mealtimes were an ongoing topic at the meetings, as were the proposed improvements to the building. Discussions included difficult issues such as the need to make savings and how this could be done. People were asked if they wanted to be involved in these discussions, so any changes could be agreed by the management and people living in the home. Activities were one area where finances were earmarked so that improvements could be made to the layout of the rooms. The feedback from people and staff was despite considerable discussions, no action had yet been taken to address the issues and consequently no improvements to the service had been made for the benefit of people or staff.

Staff meetings were held quarterly and issues included staffing levels, care plans and who would be responsible for changes, provision of slings for hoists, training, meals and annual leave. Staff said they were involved in discussions about all aspects of the service and could put forward suggestions at any time, not just during the meetings. All of the staff we spoke with said their aim was to provide a

## Is the service well-led?

home where people were supported to live an independent life, as much as possible, and a very important part of this was people being involved in decisions about how the service developed.

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

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The provider had not ensured sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed. They had also not ensured staff and received appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they are employed to perform.

Regulation 18(1)(2)(a)

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The provider had not assessed the risks to people's health and safety during any care or treatment and make sure that staff have the qualifications, competence, skills and experience to keep people safe.

Regulation 12 (a)(b)(c).

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider had not established and operated effective systems or processes to assess, monitor and improve the quality and safety of the services provided or to assess, monitor and mitigate the risks relating to the health, safety and welfare of people and others who may be at risk. They had also not maintained an accurate, complete and contemporaneous record in respect of each person including a record of the care provided to the person and of decisions taken in relation to the care.



This section is primarily information for the provider

## Action we have told the provider to take

Regulation 17(1)(a)(b)(c)