

# G & A Investments Projects Limited

# Pinewood Rest 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 visit took place on 22 and 23 November 2017 and was unannounced.

Pinewood Rest Home 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.

Pinewood Rest Home provides accommodation and personal care for up to 16 older people in one adapted building. The home does not provide nursing care. There were 12 people using the service at the time of this inspection, some of who were living with dementia.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection of this service in August 2015 we found that the systems in place to assess, monitor and improve the quality and safety of the service were not always operated effectively.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question Well Led to at least good.

At this inspection we found that some improvements had been made. The registered manager had implemented more comprehensive audits and the provider had made improvements to the home environment. However, the quality assurance systems were not robust and did not identify shortfalls in records and training. There was not a culture of continuous improvement and learning in the service. Service development planning needed to be introduced and for the registered manager to update her knowledge about the regulations and legislative framework.

Staff had not all received a comprehensive training programme, supervision and appraisal to support them to meet the needs of people living in the service.

The procedures and guidance for staff for the administration of 'as required' medicines were not safe so there was a risk of people not receiving their prescribed medicines, or receiving them inappropriately.

The procedures for obtaining consent to care and treatment did not reflect current legislation and guidance. There was a lack of understanding about who could consent to care being provided. Although the registered manager was aware of the need to apply for Deprivation of Liberty Safeguards (DoLS), this had not always been done appropriately.

People's care records were not always up to date, relevant and accessible and did not evidence how people were involved in the process.

Quality assurance systems were still not robust and consistently applied in order to assess, monitor and improve the quality and safety of the service.

The system for ensuring all recruitment information was readily available to support the provider and registered manager to make safe recruitment decisions was not always effective.

There were sufficient staff deployed.

The majority of people we spoke with told us they always enjoyed the meals. People received appropriate support to eat and drink enough to meet their needs.

People were referred to other healthcare services when their health needs changed.

Staff respected people's privacy and dignity and were responsive to their needs, choices and preferences.

People spoke positively about the service, staff and registered manager. There was a person centred culture at the home. Staff had positive caring relationships with people and supported them to make choices about their care.

People and relatives we spoke with told us they had no complaints and were comfortable to raise any concerns if they had them.

We found five 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 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.

Medicines were not always managed to ensure people received them at appropriate times.

Fire safety records had not been appropriately maintained and the provider was not aware of the action taken to update the action plan.

Staff recruitment information was not always readily available to support safe recruitment decisions.

People were protected from the risk of harm or abuse because staff understood their responsibilities.

Staff were deployed in sufficient numbers to meet people's needs.

### Is the service effective?

**Requires Improvement** 

The service was not always effective.

Staff had not all received comprehensive training and support to help them to meet the needs of people at all times.

The procedures for obtaining consent to care and treatment did not reflect current legislation and guidance. There was a lack of understanding about consent.

People had enough to eat and drink and mealtimes were a relaxed experience for people.

People were referred to other healthcare services when their health needs changed.

### Is the service caring?

**Good** 

The service was caring.

Staff had positive caring relationships with people and supported them to make choices about their care.

Staff respected people's privacy and protected their dignity.

### Is the service responsive?

The service was not always responsive.

Care records were not always up to date, relevant and accessible and did not show how people were involved in their care.

People spoke positively about the service and confirmed the staff were responsive to their needs.

There was a system and procedure to record and respond to any concerns or complaints about the service.

The service provided emotional support to relatives and visitors while providing care for people at the end of life.

**Requires Improvement** ●

### Is the service well-led?

The service was not always well led.

Quality assurance systems were still not robust and effective in monitoring and improving the quality and safety of the service.

There was not a culture of continuous development, improvement and learning in the service.

The registered manager had an open door policy and worked alongside staff. Staff felt supported by the registered manager.

**Requires Improvement** ●

# Pinewood Rest 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 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.

This inspection visit took place on 22 and 23 November 2017 and was unannounced.

The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case the expert by experience had personal experience of caring for someone living with dementia who had used residential services for older people.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with six people who lived in the home and two relatives / visitors. We observed care and support being delivered in communal areas of the home to help us understand the experience of people who could not talk with us. We spoke with the registered manager and three members of the care staff.

We looked at a range of documents including care records, risk assessments and medicine charts for seven people, staff recruitment and training records. We also looked at information regarding the arrangements for monitoring the quality and safety of the service provided within the home.

Before and after the inspection visit we received feedback about the service from two community care professionals.

# Is the service safe?

## Our findings

At our last inspection in 2015 people and their relatives told us they felt care was delivered in a safe manner. At this inspection people told us the same and all comments we received were positive.

Systems were in place to help ensure people's medicines were managed safely. People had individual support plans in relation to their medicines, including short term care plans for periods when people were on courses of antibiotics. The training record showed that five staff and the registered manager were trained to give people their medicines, and the rota was organised to cover this need.

Two people were each prescribed a medicine to be taken 'twice daily as required'. A member of staff showing us the medicines procedures was not sure under what circumstances the medicine should be given to one person. They were able to describe some behaviours or symptoms that could indicate an appropriate time when the other person may be offered their 'as required' medicines. There was a lack of clear protocols recorded for 'as required' medicines, which the registered manager acknowledged needed to be developed further, as there was a risk of people not receiving their prescribed medicines, or receiving them inappropriately, if staff did not know when they should be given.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The fire safety records were incomplete and there was no evidence of the completion of the fire safety action plan. There had been changes in personnel responsible for maintenance. The registered manager said she would ask the provider if the actions had been completed and if there was any evidence of this. Following the inspection the registered manager told us the provider was not aware of the issue with the fire records. It was therefore not possible to know what, if any actions had been completed from the fire safety action plan. The registered manager later informed us the provider was not aware of the action plan and the manager had contacted the previous maintenance person to ask them to provide details of work they had undertaken while employed at the service. The registered manager said they would send us further evidence as soon as it was available. We received evidence from the registered manager that the previous maintenance person had completed work in July 2017.

The service had a 'grab file' containing guidance for staff on what to do in an emergency, such as a fire, flood or heating breakdown. The file included a summary of each individual's needs, to support staff and external agencies to continue to meet their needs in the event of an emergency.

A system was in place to keep track of and record relevant checks that had been completed for staff who worked in the home. We looked at the records of three staff recruited since the last inspection. There was evidence of satisfactory Disclosure and Barring Service (DBS) clearance. DBS checks enable employers to make safer recruitment decisions by identifying candidates who may be unsuitable to work with adults who may be at risk. However, two recruitment files did not contain evidence of the applicants' full employment history, which meant that periods of possible employment may be unaccounted for. Although the

registered manager provided us with the information we needed during the inspection, we could not be assured that this information had been readily available for all prospective staff prior to an offer of employment having been made. The system the registered manager had in place for checking this information was available had not been effective.

We recommend the provider reviews the effectiveness of their current system for ensuring all recruitment information is readily available to support them to make safe recruitment decisions.

The registered manager told us they had recently been working shifts as part of the care team due to night staff shortages. The service was now fully staffed with 18 full and part time staff, not including the registered manager. There were three care staff on duty in the mornings, two in the afternoon and two at night. People confirmed and we observed that there were sufficient staff deployed to meet people's needs.

Risks to people's health and wellbeing were assessed and staff demonstrated that they understood people's risks, such as the risks of people falling or developing pressure wounds. People were supported in accordance with their risk management plans. Staff showed awareness of risk in day to day activities. For example, during lunch people were coming into the dining room as independently as possible, some using walking frames. A member of staff moved a walking frame and told us "We tend to put these in the lounge during lunch so no one falls over them."

Staff had continued to be trained in safeguarding policies and procedures and knew how to follow them should the need arise. Staff were confident that any issues they reported would be responded to appropriately by the registered manager. A copy of the safeguarding and whistle blowing policies was on display in the entrance area.

Staff received training in infection prevention and control (IPC) and there were daily cleaning schedules, regular checks and audits. Hand gel was available near the entrance and in other areas of the home. Personal protective equipment such as disposable gloves and aprons were available and being used by staff. A small laundry room was kept locked when not in use and contained two separate sinks for hand washing and sluicing.

Two members of staff were named IPC leads and had responsibilities that included checking cleaning products were suitable, and that staff were using suitable equipment and following good practice guidelines. The registered manager maintained a file of IPC procedures and an annual statement of how standards were being met.

All of the beds in the home had been renewed since the last inspection. People had individual locked wall cabinets in their bedrooms where their personal creams and topical lotions were stored. This promoted people's dignity and reduced the risk of cross infection.

The food hygiene rating remained a four following a recent inspection by the relevant authority, which indicated a good standard. The highest rating is a five.

An external company had carried out testing for Legionella in September 2017 and work was underway making improvements following the recommendations in the survey report.

Toilets were adequately supplied with toilet rolls, paper towels and liquid soap. All had adaptive frames fitted over them, which were stained underneath. Before 12:00 we saw one frame had been taken off the toilet and a member of the housekeeping staff told us they cleaned the toilets while people were having



lunch. At 13:00 the frames were still stained underneath. We informed the registered manager of this who agreed to follow this up with the housekeeping staff.

## Is the service effective?

### Our findings

Staff had not received a comprehensive training programme to support them to meet the needs of people living in the service. There were 18 staff in total including the registered manager. There was a record of the dates individual staff had been given training, which was mostly computer based. The training record showed that staff had received training in a range of relevant subjects that included, for example, safeguarding, fire safety, moving and handling, infection control and first aid.

However, the service provided care to older people including those living with dementia. Five staff had received dementia awareness training between 2011 and 2014 and another five in 2016-17. The registered manager had last undertaken the training in 2012. A recently recruited member of staff said they had not had dementia awareness training. They said "I like to sit and talk and listen" to people. They told us how "Staff put music on and distract" a person who often became confused and attempted to leave the home because they "think they're going to work".

They commented that another person "Kicks off every afternoon at four o'clock". They said the person "Gets up and wanders about, goes in the kitchen and nicks the biscuits". They told us that in response to these behaviours "Staff sit with her, hold her hand and reassure her". The lack of training meant not all staff knew how to support and respond to people living with dementia.

Five staff, not including the registered manager, had received training in equality, diversity and human rights (EDHR) during 2013-14. The registered manager told us one or two staff had recently completed a distance learning course on this subject in their own time. No specific work had been undertaken to support staff to meet the needs of people with protected characteristics.

A small number of staff had recently completed training in subjects such as depression, skincare and arthritis.

A recently recruited member of staff told us they had started their employment by 'shadow working' alongside the registered manager and an experienced member of staff. They told us and their records confirmed they had received a range of essential health and safety training. They told us they had not heard of the Care Certificate and an induction checklist in their records was blank. The registered manager confirmed the member of staff had the relevant workbook and the member of staff's supervision records for September 2017 indicated they were working toward completing the Care Certificate. The Care Certificate is designed for new and existing staff, setting out the learning outcomes, competencies and standards of care that are expected to be upheld. Two other staff whose records we saw had completed induction checklists in their records. They had not received any specific training in relation to EDHR. They said they would read people's care plans or ask the manager about any issues.

The member of staff told us that, while they received no formal supervision, "We talk about people, their needs, each day". The registered manager told us it was difficult for all staff to attend one to one supervisions. They had implemented a checklist to record their direct observations and feedback to staff

about work performance and standards, which they said they and staff found more practical.

A more experienced member of staff thought they may have had dementia awareness and EDHR training. They told us "It's a small home, we know our residents. Everyone is treated as an individual".

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

The Mental Capacity Act, 2005 (MCA) provides a legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision should be made involving people who know the person well and other professionals, where relevant.

The Care Quality Commission (CQC) monitors the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm.

Nine staff had completed MCA training during 2013-14 and one member of staff in 2017. The registered manager and two current staff had completed training about consent in June 2016. We could not be assured that staff understood the importance of consent. Staff told us how they encouraged people to make choices and decisions and said senior staff would deal with MCA matters. People confirmed staff asked for their consent. One person told us "They ask 'do you want this?' They don't say I have to do things".

However, there was a lack of understanding around MCA and DoLS in some areas. A community care professional told us "I find the care plans and carers recording to be detailed, but have had to remind Pinewood to complete mental capacity assessments". There was a lack of understanding about who could consent to care being provided. A person's relative who did not have the relevant power of attorney had signed the care plan, indicating their consent. This had not been identified as an issue until an external assessor had asked for care plans to be reviewed in the light of inconsistencies such as this.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the registered manager was aware of the need to apply for DoLS, this had not always been done appropriately. One application had been submitted when the person had capacity to consent. For another person, the registered manager was not clear if a DoLS applied when the person's needs had changed.

The majority of people we spoke with told us they always enjoyed the meals. One person said "It's 50:50. Some days it's good". Another person told us "It's very nice. We sit at the table and they give us what they've cooked. If you don't like it you just say and they will bring you something else". Another person said "They know what I like and I think that's what they cook for me"; and "I have porridge for breakfast. I've been doing that for years". People told us they were able to have snacks if they were hungry between meals. A person told us ""I go down to the kitchen and ask for something. I'm well fed".

Mealtime was a relaxed experience for people. At lunch time in the dining room people were having roast beef, Yorkshire pudding, roast potatoes and vegetables. The food looked and smelled appetising. Music was playing and staff were present and assisted people with cutting up their food if required.

Each person had a nutritional assessment and support plan and information about people's dietary needs and preferences was also listed in the kitchen. The majority of people were able to eat independently and only two people required support. The registered manager confirmed no-one living in the home had particular or specialist dietary needs. One person had insulin controlled diabetes and so staff supported them in monitoring their sugar intake. Another person's care notes specified they could not have a particular type of fruit.

The service continued to support people to access healthcare services and, where necessary, a range of healthcare professionals were involved in assessing and monitoring their care and support to ensure this was delivered effectively. This included GP and community nursing services, chiropody, occupational therapists, opticians and dentistry.

Since the last inspection the home had been redecorated and carpets replaced with new laminate flooring, which was better suited to people's needs as well as easier to keep clean. The maintenance arrangements had recently changed with an external company providing these services since August 2017.

There was a ramp and also separate steps to the front door of the home. The front door was locked and there was a doorbell to gain access. The home was set over two floors with a stair lift and staircase providing access between floors.

# Is the service caring?

## Our findings

Staff developed and maintained positive caring relationships with people and supported them to make choices about their care. There was a person centred culture at the home. The registered manager was available on a daily basis to talk with people who lived in the home, visitors and staff, which helped to ensure that the people receiving care were at the heart of the service. Staff we met were friendly, polite and helpful. A member of staff told us "Treat people how you'd like to be treated".

A person told us staff were "Very good. They're friends really". Another said "We have a laugh between us". One person told us "We get on very well" and "They will willingly do things for me". We observed a member of staff knocked on the person's door and entered to check how they were. They asked how the person was and said "Have you finished your coffee? Oh its cold, let me get you another". They returned with a cup of coffee. The person told us "I can't say there is anything I dislike. You don't want for anything. I enjoy being here. It's more or less like being at home". A person who was sat in the hall said "I like to watch people coming past here. You get to know everyone". We saw staff stopping to chat to them. The person told us "Everything is perfect. I wouldn't like to go anywhere else". Another person commented "It's very nice here, quite relaxing" and "I like it and we get well looked after".

Two relatives said "It's nice and friendly" and "The staff welcome you at the door and know us by name". One of them told us "One day (the other relative) didn't come in and the staff phoned to see if he was alright; that is above and beyond". Another relative had written to the registered manager and staff, thanking them for their helpfulness and support, stating: "The care my father has had is excellent".

People were supported to make decisions about their day to day care. A person told us "I get up on my own when I'm ready" and "I like a bath. I can have one any day". Another person said "I press that (buzzer) and they help me get up. I have breakfast in my room and watch the news on the television".

People and their relatives told us the staff respected people's privacy and protected their dignity. Rooms with double occupancy had curtains that could be pulled between the beds for privacy. Staff gave examples of respecting people's privacy and dignity and demonstrated their awareness of the importance of protecting people's confidentiality. People's personal information was held securely in locked filing cabinets when not in use.

A community care professional told us "The care workers I have met at Pinewood appear to know their job and needs of residents, and appear caring and I have seen them interact with the residents every time I have visited. I feel Pinewood creates a homely environment for the residents. The residents and their families I have spoken to all speak highly of the care staff and the manager". They said "When I have visited residents to carry out reviews, assessments, they appear to be very well looked after, and all of them have told me they are happy living at Pinewood".

## Is the service responsive?

### Our findings

People were positive in their comments about the service and confirmed the staff were responsive to their needs. People's comments included: "You know if you're in trouble exactly who to go to. You press the buzzer and someone comes running"; and "When I'm in bed I just press the red button"; and "[Manager] always phones and the doctor visits".

A community care professional told us "Pinewood are a small home and I feel they are able to manage residents with less complex needs better". They said "Pinewood are prompt at requesting the GP to visit a resident when necessary, and families say they are kept informed by Pinewood of any change in condition with their family member".

A person had recently moved to another service as the home could no longer meet their needs. The registered manager told us the home did not admit people with behaviours that might challenge others. However records and feedback from a community care professional showed that some people developed complex behaviour and staff struggled to support this appropriately.

The relevance and accessibility of care records was an area for improvement. Before the inspection we had received feedback from a community care professional that included concern about the relevance of care plans and reviews.

The service involved people, their relatives and external professionals in an assessment of the person's needs before they moved into the home. Care plans provided information about how each person would like to receive their care and support, including how they communicated their needs and preferences. Each person's plan reflected the importance of meeting their needs in ways that gave them as much choice and control as possible.

While the care records we saw provided evidence of a personalised approach, records of reviews appeared repetitive and did not evidence how people were involved in the process. The record of a person's 'Review of all care plans' in October 2017 stated the aim was to 'ensure (person) is given choices and respect. Follow care plans'. The same was recorded in November 2017.

A person's falls risk assessment was dated April 2015 and the person had been assessed as having a low or no risk of falls. There was a lengthy 'monthly review' list up until November 2017, with no changes reported. An incident report dated March 2017 had been recorded after the person had fallen, hitting their head, and been taken to hospital. A 24 hour monitoring record had been maintained following their return. The incident was not reflected in any way on the person's falls risk assessment or mobility care plan.

The person occasionally became upset, anxious or emotional. An incident report dated May 2017 recorded how the person had tried to hit and scratch staff for a period of around two hours. Staff had taken action including getting the person tested for a possible infection. The person had a care plan that stated they could become agitated and get stomach pains so staff were to monitor them for signs of constipation. While

this indicated a possible link to behaviour, the records lacked any more specific assessment and information to assist staff in identifying symptoms and causes and appropriate support.

At the front of the person's care file there was a DoLS assessment and application record dated 2014, which was no longer relevant as the person was not under a DoLS authorisation.

Care plans did not always refer to aspects of care such as whether people were able to use a call bell or whether the bed rails on profiling beds were used or not. For example, one person did not have a call bell in their room. The registered manager said the person would not use it and at night staff would hear if the person got out of bed. The person's night time care plan indicated staff checked on the person each hour and sometimes the person came downstairs for a drink or snack. The care plan did not refer to the call bell.

Another person's monthly falls risk assessment had most recently been reviewed in August 2017. The records also indicated the person had a fall in the shower after this date. A moving and handling risk assessment in relation to using the stair lift and bath hoist had also been reviewed in August 2017 and was due to be reviewed the following month but this record was also not on file.

We also saw daily care notes and records of monthly key worker reviews. These and the care plans did not clearly demonstrate how people were being involved in their care and support on a regular on-going basis. The registered manager had ideas for simplifying the care records and increasing service user involvement, which were discussed during the inspection.

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

The registered manager confirmed there was no-one living in the home that had an identified sensory impairment, for example a registered blind person.

The registered manager told us the local Church of England church provided a service on the last Friday of the month. They said there was also a local Catholic church who would provide Holy Communion if required.

There was a notice board displaying weekly activities that included quizzes, bingo, arts and crafts, skittles, armchair exercises, foot spa, manicure and board games. There was no day specified as to when these activities took place. The cook facilitated activities during the afternoons. Staff spent time talking with people during the day and there was a relaxed pace and atmosphere in the home. A person told us "I do lots of knitting" and showed us a drawer full of wool; "I like to stay in my room but I do go downstairs with the others". Another person said "I come down here in the morning and then after lunch I go to my room to watch a film". They said "Sometimes I go out with a friend. To (shops) and buy a new top".

The registered manager told us they had received no formal complaints. There was a system and procedure to record and respond to any concerns or complaints about the service. People and relatives we spoke with told us they had no complaints and were comfortable to raise any concerns if they had them.

The registered manager said people's end of life wishes and plans were not often discussed with them and were usually family decisions. We saw one person's end of life plan that had been signed by the person's family and included a chosen funeral director. Do not attempt cardio-pulmonary resuscitation (DNACPR) decisions were recorded where appropriate.

The service provided emotional support to relatives and visitors while providing care for people at the end of life. A relative, whose mother had received care at the home, wrote thanking the registered manager and staff "For the wonderful care you gave" and for "Knowing she was in your care, safe and very happy". They wrote: "She referred to all of you as family. Pinewood became her home, she loved the staff bringing in children, grandchildren and pets, letting her cuddle or spoil them". The relative also thanked the registered manager and staff for the support they gave to the family after their mother passed away.



## Is the service well-led?

### Our findings

At the last inspection we found quality assurance systems were in place but were inconsistently applied. The provider did not carry out regular quality assurance visits and the registered manager had limited financial autonomy to make improvements.

Following the inspection the provider and registered manager sent us an action plan describing how the maintenance and renewal of the environment would be carried out.

During this inspection we saw the registered manager had implemented more comprehensive audits and the provider had made improvements to the home environment. This had included painting the handrail in the hall a different colour to the surrounding wall in order to assist people with cognitive or sensory impairment. Some improvements, including blinds, light shades and pictures, had been purchased following a donation from a relative. However, the quality assurance systems were not robust and did not identify shortfalls in records and training. The fire safety action plan had not been monitored effectively to ensure actions were completed and in a timely way. People's care plan reviews had not ensured their on-going relevance and accuracy and some required updating.

Service development planning needed to be introduced and to include staff training needs such as equality, diversity and human rights (EDHR), The Mental Capacity Act, 2005 (MCA), and dementia. Also the registered manager updating her knowledge about the regulations and legislative framework, such as expanding her understanding of the Deprivation of Liberty Safeguards (DoLS).

There was not a culture of continuous improvement and learning in the service. While a member of staff was able to locate where the EDHR policy was kept, the principles of this policy were not communicated to or discussed with staff in a clear and consistent way, in order to ensure the service can meet the needs of people with protected characteristics at any time.

A member of staff said there had not been a team meeting since they started work six months ago. We saw the minutes of a staff meeting held on 18/10/2017. The minutes of the previous meeting were dated 17/11/2016.

There was not a robust system to gather people's views and obtain feedback. The service had a feedback form that had been completed by two people in 2017. We discussed with the registered manager how the questionnaire could be incorporated into the key worker meeting records; and also about implementing a relatives survey in order to actively seek feedback from stakeholders.

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

The registered manager had identified within the Provider Information Return (PIR) some of the areas for further development, including increasing and maintaining staff training, supervision and appraisal;

involving people and their families more; and updating her knowledge.

Staff felt they would be supported by the registered manager to raise any issues or concerns. The registered manager had an open door policy and was available on a daily basis to talk with people who lived in the home, visitors and staff.

The previous inspection report was available within the service and the rating was displayed.

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 | <p>Regulation 11 HSCA RA Regulations 2014 Need for consent</p> <p>The procedures for obtaining consent to care and treatment did not reflect current legislation and guidance. Care and treatment was not always provided with the consent of the relevant person. Regulation 11</p>  |
| Regulated activity   | Regulation  |
| Accommodation for persons who require nursing or personal care | <p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The procedures and guidance for staff for the administration of 'as required' medicines were not safe so there was a risk of people not receiving their prescribed medicines, or receiving them inappropriately. Regulation 12 (2) (g)</p>   |
| Regulated activity   | Regulation  |
| Accommodation for persons who require nursing or personal care | <p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>People's care records were not always up to date, relevant and accessible and did not evidence how people were involved in the process. Regulation 17 (2) (c)</p> <p>Quality assurance systems were still not robust and consistently applied in order to assess, monitor and improve the quality and safety of the service. Regulation 17 (1) (2) (a)</p> |
| Regulated activity   | Regulation  |

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

Staff had not all received a comprehensive training programme, supervision and appraisal to support them to meet the needs of people living in the service. Regulation 18 (2) (a)