Eastfield Care Homes Limited

Eastfield Nursing 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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on the 27 and 28 February 2017 and was unannounced. At the last inspection on 22, 26 and 28 October 2015 we found the provider (who is also the registered manager) had breached seven of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (HSCA 2014). These breaches related to Regulation 9 (Person centred care), Regulation 10 (Dignity and respect), Regulation 11 (Need for consent), Regulation 12 (Safe care and treatment), Regulation 17 (Good governance), Regulation 18 (Staffing) and Regulation 19 (Fit and proper persons employed).

At our last inspection the registered manager had not always ensured people's preferences in relation to their food choices were met, that people were treated with compassion at all times and that appropriate action had been taken to ensure consent had been sought for all aspects of people's care. The registered manager had also not always ensured that people were protected from risks associated with falls, the registered manager did not have effective quality assurance processes in place and records did not reflect the care and treatment people received. The registered manager had also not always ensured that staff received the appropriate supervision and support in their role and that people were protected from the employment of unsuitable staff.

We told the registered manager they needed to take action and we received two reports setting out the action they would take to meet the regulations. At this inspection we reviewed whether or not these actions had been taken and whether the registered manager was now meeting the requirements of the HSCA 2014. We found improvements had been made regarding the breaches identified; however, additional time was required to ensure these improvements were embedded and sustained in staff's working practices.

Eastfield Nursing Home, to be referred to as the home throughout this report, is a home which provides residential and nursing care for up to 52 older people who have a range of needs, including those living with Parkinson's disease and dementia, sensory impairments as well as epilepsy and diabetes. The home is situated in a residential area in the village of Liss and has approximately five and a half acres of land which includes a secure garden for people to enjoy at the rear of the home. Facilities include a small dining room, conservatory seating area and large lounge on the ground floor with two smaller lounges on the first floor. At the time of the inspection 46 people were using the service.

The home has a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like 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.

People were kept safe as the registered manager ensured sufficient numbers of staff were deployed in order to meet people's needs. In the event of unplanned staff shortages the registered manager sought to use familiar and known agency staff to support people with their care. However, people told us they often had a protracted wait to receive care after requesting staff assistance. Staff deployment was not always monitored

to ensure that people were receiving care at the time they required. Plans were in place to address this immediately following the inspection; however, time is needed to ensure this system is effective and improves the response people experience when using their call bells.

Staff were able to demonstrate that they complied with the requirements of the Mental Capacity Act 2005 when supporting people during their daily interactions. This involved making decisions on behalf of people who lacked the capacity to make a specific decision for themselves. However, we could not always see that people had always been accurately assessed to identify whether they were clearly able to make decisions regarding all aspects of their care.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager showed an understanding of what constituted a deprivation of person's liberty. People had been appropriately assessed as to whether they could consent to living at the home prior to the provider appropriately submitting the required applications where people were deprived of their liberty. Authorisations had been granted by the relevant supervisory body to ensure people were not being unlawfully restricted. Conditions applied to such authorisations had been recognised by the registered manager; however, we could not see that appropriate action had always been taken to ensure these conditions were met. Where conditions relating to a person's DoLs authorisation are not met it could mean the DoLS would cease to be in the person's best interest. This would place the person at risk of being deprived of their liberty without lawful authority.

The home provided care for those living with dementia however we could not always see that the environment supported these people to move around the home independently. We have made a recommendation that the registered manager seeks guidance on how to develop the home to become more accessible to those living with dementia.

The registered manager had not always fulfilled their legal requirements by informing the Care Quality Commission (CQC) of notifiable incidents which occurred at the service. Notifiable incidents are those where significant events had happened. This allows the CQC to monitor that appropriate action was taken to keep people safe. However, positive action had been taken to address this and we could see at the time of the inspection notifications were submitted in a timely fashion.

People using the service told us they felt safe, relatives agreed they felt their family members were kept safe whilst living at the home. Staff understood and followed the registered manager's guidance to enable them to recognise and address any safeguarding concerns about people.

People's safety was promoted because risks that may cause them harm had been identified and guidance provided to manage these appropriately. Appropriate risk assessments were in place to keep people safe.

People were protected from the unsafe administration of medicines. Nurses were responsible for administering medicines and had received additional training to ensure people's medicines were administered, stored and disposed of correctly. Nurse skills in medicines management were regularly reviewed by managerial staff to ensure they remained competent to administer people's medicines safely.

Recruitment procedures were completed to ensure people were protected from the employment of unsuitable staff. New staff induction training was followed by a period of time working with experienced colleagues. This ensured staff had the skills and confidence required to support people safely.

People were supported by staff who had up the most relevant up to date training available which was

regularly reviewed to ensure staff had the skills to proactively meet people's individual needs.

People were supported to eat and drink enough to maintain a balanced diet. We saw meals were prepared to meet people's individually assessed nutritional requirements. Staff followed guidance in people's care plans to ensure they received a meal which met their needs. Alternatives were offered and prepared when people did not wish to choose from the two meal choices offered and people were encouraged to eat and drink sufficient to maintain their health and wellbeing.

People's health needs were met as the staff and the registered manager had detailed knowledge of the people they were supporting. Staff engaged with healthcare agencies and professionals when required. This was to ensure people's identified health care needs were met and to maintain people's safety and welfare.

Staff had taken time to develop companionable relationships with the people they were assisting. Staff understood people's communication needs and used non-verbal communication methods where required to interact with people. These were practically demonstrated by staff during their interactions with people.

People received respectful care from staff who understood their care needs. People had care and support which was delivered by staff using the guidance provided in individualised care plans. Care plans contained information to assist staff to provide care in a manner that respected each person's individual requirements. Although this information was not always completed fully we could see that staff knew how to support people in the way they required.

People were supported to participate in activities to enable them to live interesting lives and prevent them experiencing social isolation. A range of activities were available to people to enrich their daily lives which were promoted by staff to ensure people were able to participate in, if they wished to do so.

Relatives knew how to complain and told us they would do so if required. Procedures were in place for the registered manager to monitor, investigate and respond to complaints in an effective way. People and relatives were asked to complete a biannual quality assurance questionnaire to provide their views on the quality of the care and support provided. An action plan was then created to ensure people's views were documented and positive action taken to address and areas raised.

The registered manager had a philosophy of care which detailed the way in which care would be delivered to people. Staff we spoke with were able to recognise what this philosophy of care meant we saw these standards were evidenced in the way care was delivered to people.

Relatives told us and we saw that the home had an actively involved registered manager and staff told us the registered manager provided strong leadership and was readily available to them.

Quality assurance processes were in place to ensure that people, staff and relatives could provide feedback on the quality of the service provided. The registered manager routinely and regularly monitored the quality of the service being provided in order to drive improvement.

We found a continuing breach of the HCSA; you can see what action we asked the registered manager to take at the back of the full version of this 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.

People were supported by sufficient numbers of staff who had been subject to a robust recruitment procedure ensuring their suitability to deliver care. However staff deployment was not always monitored to ensure people were receiving care in a timely fashion after they had requested assistance from staff.

People were safeguarded from the risk of abuse. Staff were trained and understood how to protect people from abuse and knew how to report any concerns.

Risks to people had been identified, recorded and detailed guidance provided for staff to manage these safely for people.

Medicines were administered safely by nurses whose competence was assessed by appropriately trained managerial staff.

Is the service effective?

Requires Improvement

The service was not always effective.

People were assisted by staff who demonstrated they offered people choices in ways which they could understand and respond to. However MCA assessments regarding people's ability to make decisions relating to all aspects of their care had not been completed fully. It was not always clear that conditions attached to people's authorisations regarding restrictions to their freedom had always been actioned.

The registered manager ensured that staff had the relevant induction, on-going training and support to be able to meet people's needs and wishes.

People were supported to eat and drink enough to maintain their nutritional and hydration needs. People who had specific needs in relation to eating and drinking were provided with the additional support required to protect them from any associated risks.

Staff understood and recognised people's changing health needs and promptly sought healthcare advice and support for people whenever required.

Is the service caring?

Good

The service was caring.

Staff were compassionate and caring in their approach with people, supporting them in a kind manner. Staff had developed companionable and friendly relationships with people.

Where possible people were involved in creating and reviewing their own personal care plans to ensure they met their individual needs and preferences.

People received care which was respectful of their right to privacy and maintained their dignity.

Is the service responsive?

Good

The service was responsive.

People received care that was based on their needs and preferences. They were involved in all aspects of their care and were supported to lead their lives in the way they wished to.

People were assisted by staff who encouraged people to participate in activities to allow them to lead full, active and meaningful lives.

Processes were in place to ensure complaints were documented, investigated and responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not always well led.

Staff told us the registered manager provided positive leadership however they had not always fully complied with the legal requirements of their role. Documentation relating to people's care had not always been fully completed to ensure the care being delivered was in people's best interests.

The registered manager promoted a culture which was based on being open, honest and treating people with respect and dignity. Staff knew these values as these were evidenced in their working practices.

Staff were aware of their role and felt supported by the registered manager.

The registered manager sought feedback from people and their relatives and acted upon this. They regularly monitored the quality of the service provided in order to drive improvement.

Eastfield Nursing 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 registered manager 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 27 and 28 February 2017 and was unannounced; it was conducted by three inspectors, an Expert by Experience (ExE) and a Specialist Advisor.

An Expert by Experience is someone who has personal experience of using or caring for someone who use this type of care service; on this occasion they had experience of family who had received nursing care. The Expert by Experience spoke with people using the service, a relative, observed meal time sitting and interactions between staff and people living at the home.
A Specialist Advisor is someone who has specific knowledge, experience and understanding of a particular aspect of care. The Specialist Advisor was a registered social worker with experience of managing residential care homes for older people and those living with dementia. They were also trained and experienced in the application of the Mental Capacity Act 2005 and compliance with the Deprivation of Liberty Safeguards.

Before our inspection we looked at previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is information about important events which the service is required to send us by law. We had not requested a Provider Information Return (PIR) before the inspection. A PIR is a form which asks the provider to give some key information about the service, what the service does well, and what improvements they plan to make. We checked this information as part of our inspection.

During the inspection we spoke with eight people living at the home and two relatives, the registered manager (a registered nurse), the deputy manager (also a registered nurse), two nurses, four health care assistants, a senior health care assistant, the activities coordinator and the home's cook.
We reviewed care documentation relating to 17 people, three of the same people's daily care records and 20 medicine administration records. We reviewed 12 staff files which included recruitment and training details, viewed staff supervision and appraisal dates, staff training records and staff rotas for the dates 27 January to

27 February 2017. We also reviewed other documentation relating to the running of the home, these included quality assurance audits, the provider's policies and procedures, complaints, compliments, accident and incident forms and maintenance records. Following the inspection we spoke with a healthcare professional and two further relatives.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe or very safe as staff were able to offer reassurance when required. This was a view confirmed by relatives and a healthcare professional we spoke with.

At our previous inspection of 22, 26 and 28 October 2015 we found the registered manager had failed to take action to ensure all people living at the home had risk assessments in place regarding people's risk of falls. When people had experienced a fall the registered manager had not consistently completed the necessary post falls observations. These are necessary to ensure that any post fall complications are identified which allow for further potential medical intervention to be taken if required. At the previous inspection people had also not always been protected from the risk of the employment of unsuitable staff. Full employment histories had not been requested or obtained from prospective staff to ensure that any gaps in their employment could be reasonably explained.

At this inspection we found improvements had been made and risks to people's health and wellbeing were identified with guidance provided to help staff mitigate the risk of harm. People's care plans included their assessed areas of risk for example, regarding their moving and handling needs, risk of skin breakdown and any identified nutritional or hydration risks. Risk assessments included information about the action staff needed to take to minimise the possibility of harm occurring to people. For example, some people living at the home had restricted mobility due to their physical health needs. Information was provided in these people's care plans which provided guidance to staff about how to support them to mobilise safely around the home and when being transferred.

Additional risk assessments were completed when required to manage new risks identified to people's safety, for example, when it had been identified that people were at risk of choking. These risk assessments were reviewed monthly. This ensured that all current risks were identified and appropriate action documented for staff to take to mitigate this risk as soon as this change in need had become known. Staff knew these risks and were able to demonstrate when supporting people how they ensured people's safety. Action had been taken and records showed the registered manager was now meeting the requirements of the regulation.

The registered manager had taken steps to ensure detailed recruitment procedures were followed to ensure staff employed had the appropriate experience and were of suitable character to support people safely. Staff had undergone detailed recruitment checks as part of their application and these were documented. These records included evidence that pre-employment checks had been completed; including obtaining written previous work references. Recruitment checks also included a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff who may be unsuitable to work with people who use care services. Nurses who wish to continue to practice in their role must register with the Nursing and Midwifery Council to keep their skills and knowledge up to date. We could see that nurses were meeting the requirements of their role and regularly renewing their registration to evidence they remained competent to continue. People were kept safe as they were supported by staff who had been assessed as suitable for the role. Action had been taken and records

showed the registered manager was now meeting the requirements of the regulation.

People we spoke with during the inspection felt there were not always sufficient numbers of staff available to meet their needs in a timely way. People we spoke with told us they would have to wait to receive support from staff when they used their call bell, this would include times when people needed help to use toileting facilities. One person told us, "Sometimes it's a long time before they (staff) come, especially after lunch", another person told us, "Sometimes staff take 30 – 40 minutes to respond". Another person told us, "When I press for help it takes a long time for staff to help me onto the commode, this morning I had to wait for at least 20 minutes", another person experienced the same concern telling us, "The staff take a long time to respond to the buzzer, sometimes I've waited up to an hour, they (staff) tell me they are busy". However, staff told us that they felt sufficient numbers of staff were deployed. Observations during the inspection showed sufficient numbers of staff were deployed to meet people's needs however, we saw call bells were not always answered promptly. On one occasion a staff member was distracted by a mobile phone whilst a call bell continued to ring which indicated somebody had requested assistance.

At the time of the inspection the registered manager did not use a staffing tool in order to determine the numbers of staff required in order to meet people's needs. The registered manager routinely worked within the home providing support for staff whilst acting in their capacity as a nurse. This allowed them to assess the numbers of staff deployed identifying whether or not additional numbers were required. The registered manager stated they would trust staff to make the decision to seek support from agency staff if required and was available for staff to share any staffing concerns they may have. The registered manager told us immediately following the inspection they would be instigating a staffing dependency tool which would allow them to objectively assess the level of people's needs and the numbers of staff required in order to meet these needs. At the time of the inspection the registered manager had identified the minimum staffing levels required in order to meet people's needs, this consisted of eleven care staff and two nurses in the morning, nine care staff and two nurses in the afternoon and three care staff and one nurse working overnight. There was no significant reduction of staffing levels at the weekends. Care staff were also supported by the registered manager, deputy manager kitchen, domestic, administration and maintenance staff on duty.

The registered manager explained that where shortfalls in staff were identified they sought the assistance of agency staff to provide cover. Most staff spoke positively about agency staff telling us the registered manager attempted to use the same staff to ensure people received care from consistent and familiar staff.

During the inspection the registered manager communicated with staff the importance of answering calls bells promptly and evidenced they would be paying to upgrade their call bell system. This upgrade would allow them to observe and audit call bell response times. This would assist them in identifying whether or not people were waiting for a long period of time for staff support after requesting their assistance. Time is needed to allow this system to be implemented to ensure that people's needs are being met in a timely fashion.

Staff were able to demonstrate their awareness of what actions and behaviours would constitute abuse. Staff were aware of their responsibilities to report any safeguarding concerns and were confident to whistle blow if required. Whistleblowing is where staff can anonymously raise concerns regarding the quality or type of care being provided. The registered manager's policy regarding whistleblowing also provided guidance for staff on how and where to raise a safeguarding concern which included contacting the county's Adult Services Safeguarding Team. The registered manager also promoted the use of the local authorities Adults Multi Agency Policy which provided staff with information regarding where and how to raise any such concerns. Staff were able to identify that they would speak to the registered manager in the event of any

concern being identified and would contact the Care Quality Commission if they felt appropriate action was not being taken. One member of staff told us, "I do feel confident in managing (safeguarding) situations and the manager will always listen". People were protected from the risks of abuse because staff understood the signs of abuse and the actions they should take if any concerns were identified.

Nurses were responsible for administering medicines. Records showed that medicine administration records (MARS) were correctly completed to identify that people received their medicines as prescribed. Nurses were also subject to annual competency assessments as part of the registered manager's training schedule to ensure medicines were managed and administered safely.

There were policies and procedures in place to support nurses to ensure medicines were managed in accordance with current regulations and guidance. We saw that nurses administering medicines followed guidance from the Royal Pharmaceutical Society to ensure this was done safely. Some people living at the home were receiving medicines which are known as PRN or 'as required' which includes analgesics, sedatives and other medicines to manage people's pain. These are medicines that are not routinely required and may only be needed occasionally. People's MARS provided guidance detailing when PRN medicines were most appropriate, and the dosage that could be given. For example, people's MARS showed when they were in receipt of medicines for pain relief, clear guidance was provided as to when it could be administered and the levels of which could be given and for how long. We observed a medicines round where the nurse appropriately supported people to take their medicines as required. When it had been identified people were suffering from allergies to certain medicines this information was made clear across people's care records and on their MARS. This allowed nurses to immediately see whether medicines prescribed were appropriate for use minimising the risk of severe allergic reactions and significant risks to the health of people living in the home.

Medicines were stored, administered and disposed of correctly which included those which required refrigeration to remain safe. The temperatures of drugs storage locations were routinely completed and documented to ensure they remained suitable for use. Some prescription medicines are controlled under the Misuse of Drugs Act 1971, these are called controlled drugs and they have additional safety precautions and requirements. Controlled drugs stocks were managed effectively and audited daily by the nurses to check that records and stock levels were correct.

Requires Improvement

Is the service effective?

Our findings

People and relatives we spoke with were mainly positive about the ability of staff to meet their and their family members care needs. One person told us, "The staff are quite good" another said "Staff are respectful when providing my personal care". This was agreed by relatives we spoke with, one relative told us, "My (family member) would go through a decline in (their) physical health and the nurses would assess (them) and know exactly what to do…the staff appear competent and know what they're doing". Another relative said, "Most of them are definitely (skilled and experienced), they (staff) work in pairs…if there is someone who is less experienced they put them with an experienced person". Another relative told us that when they spoke with staff about their relatives care staff were always able to answer their queries satisfactorily which gave them confidence in their ability. A healthcare professional spoke positively of the home telling us, "There are some very experienced staff in Eastfield who have been part of the team for a long time… relatives have reported (to me) their confidence in the staff looking after their family member".

At our previous inspection of 22, 26 and 28 October 2015 we found the registered manager had failed to ensure that appropriate and documented consent had been sought before using items such as bed rails and bucket chairs. These items can restrict people's freedom of movement. Where people do not have the mental capacity to agree to their use then there is a requirement to comply with the legal requirements of the Mental Capacity Act 2005 (MCA). This includes completing mental capacity assessments identifying if people are able to consent to their use and if not then ensuring a best interest decision making process is followed. The registered manager had also not ensured that staff were receiving appropriate supervision to ensure their competences in relation to medicines management were appropriately monitored and assessed. It had also been identified during the previous inspection that people's needs in relation to the consistency of their food and their individual food preferences had not been appropriately assessed and the necessary action taken to ensure people received the meals which met their individual needs.

At this inspection we saw that improvements had been made in relation to the requirements of the MCA however this work had not yet been fully completed for all residents. During the inspection the registered manager was in the process of moving all aspects of people's care records from being paper based to becoming computer based. People's documentation was being reviewed whilst it was being transferred onto the new system to ensure it met their needs. However, during this inspection we saw evidence where best interest decisions had not been completed fully and the requirements of the MCA were not followed fully. The registered manager acknowledged additional work was required however the new computer system would be operational by the end of March 2017 which would address the issues identified during the inspection.

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. Best interest means decisions are made on behalf of people when they no longer have the capacity to make a specific decision about their life or care. Not all the staff we spoke with were able to clearly discuss the

principles of the MCA however they were able to demonstrate how they supported people to make their own decisions during their everyday interactions.

The registered manager used the local authority's Mental Capacity Toolkit, this is a document which includes guidance for completing an assessment on a person's capacity for making a specific decision and for documenting any resulting best interest decisions made. However, we could not always see the toolkit had been completed thoroughly when assessing if people lacked the capacity to make specific decisions about their care.

For example, in one person's care plan a risk assessment had been completed for the use of bed rails. This person did not have the capacity to be able to provide their consent to their use. The risk assessment stated that informed consent had been gained from the person or the next of kin. The term next of kin has no legal meaning and there was no evidence either an attorney or deputy had been sought in respect of this resident to ensure this was the right action to take for them. The registered manager had not ensured that a MCA assessment and best interest process had been completed fully in relation to the decision to use bed rails for this person. Another person using bed rails had a completed risk assessment for their use. However, it had not been documented that consent had been sought from either the person or an appointed deputy. The form stated that if the person was unable to given informed consent a best interest form should be completed. We could not see this had been completed. The form stated that there was no next of kin and the decision to use bed rails had been made in that person's best interest, but we could not see this process had been completed fully. We could not see the appropriate MCA assessment and best interest process had been completed in relation to the decision to use bed rails for this person. This meant there was a risk that these people were receiving care which was not consented to or agreed as necessary for their best interest.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Staff were not always able to accurately describe what they understood by a DoLS however staff knew they could not stop people leaving the home if they had capacity and were not subject to a DoLS. We saw that appropriately submitted applications had been made which had been authorised successfully to ensure that people were not unlawfully deprived of their liberty whilst living at the home. However, we could not see the conditions applied by the authorising body to all authorisations were being followed fully.

One person had a DoLS appropriately applied for in relation to the use of a bucket chair as a form of restraint. Attached to the conditions of the authorisation were a number of conditions which the registered manager was required to complete to ensure the authorisation remained valid and in the person's best interest. These conditions included ensuring records were kept regarding the frequency and circumstances in which the chair would be used and a clear record of the best interest decision in relation to the use of the bucket chair. Where conditions relating to a person's DoLs authorisation are not met it could mean a DoLS would cease to be in the person's best interest. This would place the person at risk of being deprived of their liberty without lawful authority. The MCA assessment relating to the use of the bucket chair had not been fully completed. There was no detailed evidence documenting how the person had been supported to make the decision or the steps taken to explain how the information had been given in a way the person could understand. There was no evidence of how or whether less restrictive options had been considered in the best interest assessment. Following work with social services the registered manager had withdrawn the use of this chair immediately prior to the inspection and alternative seating was being sought to support this person.

The registered manager had not ensured they had always sought appropriate consent prior to the use of

items which restrict a person's liberty. This was in contrary to the MCA Code of Practice and a continuation of the breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We saw occasions where people did not have appropriate family to support them with their decision making process. When this had occurred the registered manager had promoted the use of advocates and Independent Mental Capacity Advocates (IMCAs) for people. Access to IMCAs are a legal right for people over 16 who lack the mental capacity to make key decisions about their life including major healthcare decisions or decisions about where to live, where they do not have anyone else to represent their interests. This ensured any key decisions were made in people's best interests. For example, we saw a decision had been made by an independent body which restricted one person's ability to leave the home. The home supported this person with the appeals process by arranging the use of an IMCA to ensure this person's views and wishes were accurately represented. This ensured that this person had been actively involved in the process of challenging a decision which impacted on their life to make sure their views were accurately reflected and considered.

People were assisted by staff who received a thorough and effective induction into their role. Staff induction included a period of shadowing to ensure they were competent and confident before supporting people. Shadowing is where new staff are partnered with an experienced member of staff as they perform their job. This allows new staff to see what is expected of them. One member of staff told us about the induction, "It was good, I was able to shadow for a few days and get to know the residents as well as the things I was expected to do". The induction process completed by staff followed the Care Certificate induction standards. These are nationally recognised standards of care which care staff need to meet before they can safely work unsupervised within the first 12 weeks of their employment. This induction covered a number of areas including staff understanding their new role, working with people in a person centred way, communication, awareness of mental health, dementia and basic life support.

Staff were able to access training in subjects relevant to the care needs of the people they were supporting. The registered manager had made training and updates mandatory for all staff in a number of key areas which included: infection control, health and safety, food safety and dementia awareness for example. Nurses undertook more health specific courses to enable them to support people safely. These courses included stoma care (a stoma is an opening on the surface of the abdomen which has been surgically created to divert the flow of faeces or urine), end of life care and managing syringe drivers (a syringe driver helps reduce symptoms of illnesses and medical conditions by delivering a steady flow of injected medication continuously under the skin). We asked nurses about the revalidation process which is designed to ensure all registered nurses remain competent and safe practitioners. One nurse told us, "We're aware of what we need to do (to revalidate), and the manager is quite supportive, I don't have any concerns". Staff were provided with sufficient training to enable them to conduct their role with confidence.

People were assisted by staff who received support in their role. There were documented processes in place to supervise and appraise all staff in a group supervision process to ensure they were meeting the requirements of their role. Supervisions and appraisals are processes which offer support, assurance and learning to help staff develop in their role. All of the staff we spoke with had received recent, formal supervision which had been in a group setting which documents confirmed. They confirmed that staff were able to seek a one to one supervision with the registered manager at any time they requested and were happy to do so if required.

When identified as necessary records detailing what people ate were completed to inform staff if people had received adequate food and fluid during the day. However, it was not always clearly documented on people's fluid charts what the daily amount of fluid intake they required in order to reach their hydration

needs. Staff were not able to accurately identify how much people should be encouraged to drink on a daily basis and their responses ranged from one litre to three litres. This was brought to the registered manager's attention during the inspection and immediate action taken to ensure that a daily fluid intake target was recorded on the top of people's fluid charts. This action enabled staff to see when they should be taking additional action to encourage people to drink more.
People's weights were monitored regularly and there were clear procedures in place regarding the actions to be taken if there were concerns about a person's weight. For example, it had been identified that one person had been losing weight. Appropriate healthcare professional advice was sought and a dietician visited on the day of the inspection to review this person's needs. This person's care plan had been previously been reviewed to include information that they should continue to be encouraged to eat and drink their favourite foods to improve their health and wellbeing.

Most people we spoke with were complimentary about the food provided and said they enjoyed their meals which was confirmed by our observations. One person told us, "The food is very good and so is the choice, it's nutritious and I do think we have enough fruit and vegetables". Other people confirmed that they were offered choice at each meal and enjoyed the vegetables which were provided. The home did not cook its main meals and used an external food provider to supply the meals. People were offered two choices of a main hot lunchtime meal and there were alternatives people could have to ensure that differing tastes were catered for. Staff we spoke with were aware of people's likes and dislikes regarding their food and meal choices and ensured these were accommodated. We saw people's preferences regarding whether they had a 'soft' diet were accommodated. We saw choice was being offered throughout the dining periods. The cook was aware of people's food likes and dislikes and was able to cater for differing tastes if people had changed their mind from what they had ordered for lunch earlier in the day. People were also able to have snacks and drinks at any time during the day should they wish. We saw people were offered tea and biscuits on regular 'tea rounds' and this was in their preferred choice of drinking vessel. Where people wanted or needed the use of a beaker to support them to drink independently this had been documented. A few people ate in their rooms whilst others ate in the dining and lounge areas.

People were asked and encouraged to sit in the communal area to create a social environment at lunchtime. There were two meal time settings at the home, the earlier sitting allowed staff the time to support those who required extra assistance to eat and the later sitting for those who were to eat independently. We saw effort was made to try to ensure meal times were a sociable experience by bringing people together however, the environment did not always support this. The registered manager told of plans to extend various areas of the home which would assist in creating more space and allow for a more leisurely and enjoyable lunch time experience. Dining tables in the main dining room were well laid with table cloths and fresh flowers with drinks readily available for people in glasses. However, there were a lot of staff, people and visitors walking through this area of the home when people were eating to access other areas of the home. On one occasion the medicines trolley was in the dining room whilst the nurse assisted people; however, this caused difficulties with people trying to pass it once they had finished their meal sitting. This meant people were waiting to move through the dining room whilst other people were attempting to enjoy their dinner. A large dresser in the dining room with glass doors stored a number of supplies including boxes of tissues and people's combs and brushes for example, which did not help to give the room an overall feel of that of a dining room. We did see some positive interactions such as staff asking where people wanted to sit, people being given consistent one to one support and some people having clothing protectors.

People were supported to maintain good health and could access health care services when needed. Relatives confirmed their family members were supported to seek additional assistance whenever required. Processes were in place to ensure that early detection of potential illness could be identified by regular

review of people's risk assessments and care plans. Where required people were supported to seek additional healthcare professional advice including seeing a regular visiting GP, for example. When advice from healthcare professionals had been provided we could see this had been documented and staff had taken appropriate action to ensure this guidance was followed. A healthcare professional told us staff worked closely with them seeking their service for support and advice regularly to improve the quality of people's lives. For example, when caring for people whose behaviour could challenge, staff had liaised closely with them to ensure that medication provided was appropriate and any side effects of this was immediately reported allowing for alternative action to be taken. Care plans detailed how to recognise the signs of an impending health related issue and what action to take as soon as one of these incidents were recognised. For those living with conditions such as epilepsy and diabetes we could also see that guidance was provided for all staff on how to make sure these people's specific risks were easily identified and appropriate action taken to manage them effectively. There was evidence of referral to and collaborative working with healthcare professionals, families, people and staff.

Despite providing care to those living with dementia and the home being promoted as a 'dementia friendly environment' we could not see that the environment had been adapted to support people to live as independently as possible. The registered manager discussed plans they had to extend and decorate the home however at the time of the inspection the home was an older building which had not been specifically designed or decorated to meet the needs of those living with dementia. Corridors in places were not very wide to enable easy access; however, there had been the provision of additional lighting which helped the brightness of these areas. This is necessary to support those with limited eyesight associated with old age and those living with dementia. There were no contrasting coloured handrails to support those who were able to mobilise independently in the majority of the areas of the home. Differently coloured handrails provide a focal point for people living with deteriorating vision, associated with dementia allowing them to easily identify where they can seek physical support. Toilets and bathroom doors did not always have the appropriate pictorial signage to make identification easier for people. The carpet and flooring throughout the home was not always appropriate for those living with limited eyesight as it was dark in places with multiple, repeated large patterns. Changing colours and patterns of flooring can be disorientating for those who have limited visual capacity as a result of their dementia.

We recommend the registered manager seeks advice and guidance from a reputable source about developing a dementia friendly living environment.

Good

Is the service caring?

Our findings

Most people and relatives we spoke with told us that support was delivered by caring staff who took the time to get to know them and their needs. One person told us "When staff wash me down they are kind and respectful and they will always knock on my door before them come in". Another person said, "I think generally the staff are caring". One relative told us, "Yes (staff are caring)…they talk to him so they know him, and they don't just do the job". Another relative said, "Yes, yes (staff are caring), whenever we've been they (staff) always say hello to (family member) always very kind to him". A healthcare professional told us, "I have seen staff showing understanding and kindness to individuals and never been concerned about a staff member's approach towards residents".

We saw people experienced comfortable, familiar and caring relationships with staff. We observed staff being engaging with people, ensuring eye contact, listening and responding accordingly, smiling, being polite with terms of endearment being used where agreed and appropriate. During the inspection all members of staff in the home chatted to people as they went about their work. Conversations were not just orientated around the completion of tasks for people. Staff spoke to people in a warm and caring manner, and spent time chatting with them about issues they were interested in. There was a calm, relaxed and friendly atmosphere at the home. Staff interactions between people and staff were caring and professional in their approach when supporting people.

We observed care in communal areas throughout the inspection; we saw positive interactions between people and staff who consistently took care to ask permission before intervening or assisting. Staff knew some personalised information about the people they were supporting because most of the care plans viewed included some detail about what was important to them. This included information such as details of their life prior to moving to the home, their family relationships and what help they required to support them. Most people's care plans contained some personal history, what activities interested them and any talents and positive attributes they had such as raising money for charities and having a sense of humour. These were being rewritten at the time of the inspection for each person living at the home and would assist new staff by enabling them to have a greater understanding of people's needs, preferences and the support they needed to remain happy. Where this information had not been provided by family members, staff had actively sought this information from people they supported during their conversations. We could see that people's needs were known and people supported in the way they wanted. We could also see, for example, that people were respected by having their appearance maintained. Staff assisted people to ensure they were well dressed and clean, glasses were clean and the gentlemen were shaven where preferred.

People who were distressed or upset were supported by staff who could recognise and respond appropriately to their needs. Staff knew how to comfort people who were in distress. All the staff we spoke with were able to describe how they would support people in a caring way giving people the time and reassurance they required until they were no longer feeling unhappy. People were supported in periods of low moods and offered comfort and reassurance until they felt better within themselves.

Where appropriate, physical contact was used as a way of offering reassurance to people. We saw that staff

used touch support to interact with people to engage with them. When communicating staff would often gently place a hand on people's arms to communicate that they were being spoken with. We saw that people were comfortable and actively sought this physical contact with staff and visitors to the home. Friendly conversations were held whilst staff and people chatted and held hands whilst they moved around the home. One relative confirmed that the staff had been successful in building up a relationship with their family member who had been refusing to leave their room when they first moved to the home. This relative told us, "They (staff) did it all…they gradually encouraged him and now he's a completely different person… huge improvement, really done well with him, very pleased". This person now had the confidence to sit with staff in the staff room which was never discouraged and was an activity very much enjoyed by their family member.

People were supported to express their views and where possible involved in making decisions about their care and support. We found evidence that people or their representatives were invited to participate in regular and formal involvement in on-going care planning. Relatives confirmed they had been involved in this on-going process.

Most people we spoke with told us and relatives confirmed that people were treated with respect and had their privacy maintained at all times. A relative told us "When I'm in the room and they (staff want to deliver care) they say 'do you just want to pop outside'…they shut the curtains and make sure the door is shut so people going past can't see". Staff were responsive and sensitive to people's individuals needs whilst promoting their independence and dignity. People's care plans provided guidance on how to support people in a way that was mindful and respectful of people's dignity which was followed. Staff were able to provide examples of how they followed this guidance.

Staff were seen to ask people before delivering or supporting them with the delivery of care and most people we spoke with confirmed staff sought their permission before assisting them and did so in a caring and considerate way.

We saw that people's differences were respected. We were able to look at all areas of the home, including people's bedrooms. We saw rooms held items of furniture and possessions that the person had before they entered the home and there were personal mementoes and photographs on display. People were supported to live their life in the way they wanted in a homely environment which respected their individuality and met their needs.

Good

Is the service responsive?

Our findings

Where possible people were engaged in creating their care plans. People not able to or unwilling to engage in creating their care plans had nominated friends and relatives who contributed to the assessment and the planning of the care provided. A healthcare professional told us, "Residents referred (to their department) are involved as far as possible in their care; relatives are always offered to attend reviews of a resident's care when appropriate". People spoke positively about the activities provided and felt able to raise concerns with the registered manager should they have a concern or complaint about the service they were receiving.

People's care needs had been assessed and documented by the registered manager before they started receiving care. These assessments were undertaken to identify people's support needs and develop care plans outlining how these needs were to be met.

At the time of the inspection the registered manager was in the process of moving people's care documentation from being paper based to being electronically stored on the home's computer system. As a result there was a mix of paper and computer based care documentation being used by staff as guidance on the care people required.

People's care plans contained most information staff required in order to meet people's needs. However, on occasions we saw this information had not always been completed fully which could mean people may have been at risk of not receiving the care and support they required to maintain their emotional and spiritual wellbeing. For example, one person's care plan regarding their spiritual belief stated that staff should assess that person for 'spiritual pain' however no guidance was provided to staff on how this could be recognised and addressed. Another two people's care plans used the same phrase, 'Risk of spiritual distress, challenged beliefs and value systems' however no further information was provided to staff on how to recognise if someone was in spiritual pain or distress and how to manage this appropriately. The registered manager was reviewing all people's care plans whilst transferring the information to the new computer system. They stated this had increased their workload but were in the process of ensuring all care plans were reviewed as part of this changeover. Despite this information not being complete we saw people were supported to practice their religion and a vicar was invited into the home and people were supported where possible to visit a local church. One person told us, "I have a vicar come in to see me and gives me communion; this is something that is extremely important to me". This was confirmed by a healthcare professional we spoke with who said, "On observation of visiting Eastfield there is always activities going on in the home. Residents have the choice to participate in as much or as little as they choose, I have seen activities including music and sing-alongs and quizzes. Staff will take individual residents out…I have known residents taken to church in order to meet their spiritual needs".

People's individual needs were reviewed four to six weekly to ensure care plans provided the most current information for staff to follow. When identified that there had been a change in people's health care needs or people requested action to be taken on their behalf this was recorded and actioned appropriately. The home's monthly newsletter had a standing item where relatives were encouraged to participate in care plan reviews to ensure they accurately reflected the care required by their family members. When healthcare

professional advice had been sought the information provided had been used to update people's care plans accordingly.

A handover occurred between nursing staff at the start of each shift change. These were held between the nurses and this information was then shared with staff. Discussions regarding people's needs and any changes to the care they required were discussed in private and not in the public areas of the home to maintain people's confidentiality. Staff told us these were a useful process and provided them with the information they need to deliver effective care. One member of staff said, "We have a handover at 8:30 and go through every single patient in the building, any problems, if they're ok, communications book with appointments and things like that." Another person said, "They're (handovers) very good, we get every information".

The registered manager sought to engage people in meaningful activities to prevent people suffering from the risk of social isolation. People's care plans documented people's preferences for their activity choices and we could see people were actively encouraged to participate when these activities were offered. We saw that these care plans were updated when people's needs and preferences changed. For example, when people choose to spend their time in their room this was respected however attempts were made to find activities and interests they would be happy to participate in.

Most people spoke positively of the activities available and we saw that a variety of internal and external activities were provided for those living at Eastfield. The home had an activities coordinator who worked at the home all day on Mondays and provided afternoon activity sessions Tuesday through to Thursdays. Social interaction and activity stimulation was seen as part of care staff duties and on Fridays and the weekends care staff were responsible for encouraging persons to participate in activities to help them lead fulfilled lives.

The activities coordinator aimed to find out people's likes, dislikes and hobbies by completing a review assessment with people and family when they moved to the home. This enabled them to find activities which people would be able to attend which would provide them with interest in their daily lives. People were also encouraged to make suggestions regarding the types of activities they wished to participate in. During our inspection on Shrove Tuesday we observed a pancake making session which was well attended by people living at the home. People were seen to be enjoying the experience and their pancakes were shared with other people who lived in the home. During the session people were asked to suggest ideas regarding any specific events they would like to see to celebrate St Patricks Day.

Eastfield Nursing Home newsletters were displayed within the home and provided photos and information of the activities which people had participated in as well as upcoming events. In February 2017 people were encouraged to participate in various activities including: baking, trips to Petersfield, sing-alongs, family days, movie watching, one to ones, card making, trip to Petersfield's dementia group coffee mornings, harp therapy sessions and aromatherapy works. On Tuesdays a hairdresser attended the home and we saw staff interacting positively with one person who had visited the hairdresser commenting on their lovely appearance. The home also had its own hydrotherapy pool which was used by residents. For people who were unable or unwilling to join group events staff provided one to one sessions for people to ensure their risks of social isolation were minimised. Visiting musicians also visited people in their rooms enabling them to enjoy music therapy. A relative told us, "The activities lady is here most days, the ladies have their nails done or a hand massage…on a Monday morning a lady comes in and plays a harp….for those that are bed".

People and relatives were encouraged to give their views and raise any concerns or complaints. Most people and relatives were confident they could speak to the registered manager to address any concerns. The

registered manager's complaints policy was available for people in their 'Welcome to Eastfield Nursing Home' documentation which they received when the moved to the home. This listed where and how people could raise a complaint or concern if required. The registered manager's complaints policy included information on how to raise concerns with the Local Authority Ombudsmen if the complainant remained dissatisfied with the outcome of their complaint. It also included website contact details for the Care Quality Commission to enable people to raise concerns about their care if required.

Complaints received were documented and recorded in the complaints folder held securely in the registered manager's office. One formal complaint had been received since the last inspection. We saw the complaint raised was investigated by the registered manager and steps taken to address the cause of the complaint. The complaint was then responded to appropriately in accordance with the registered manager's own policy.

Requires Improvement

Is the service well-led?

Our findings

Most people we spoke with were able to identify who the registered manager was and most people, relatives and staff we spoke with were confident in the registered manager's ability to manage the service and address concerns. One person told us they felt the home was a "Well managed service". One relative told us, "He's (the registered manager) very nice, we can talk to him, he's very easy to talk to he listens, he listens to you, we've got no complaints at all". Staff and a healthcare professional told us the registered manager was actively involved in the day to day running of the service. A healthcare professional told us, "(The registered manager is) very professional in his approach to our service, residents and his staff. He has a good understanding of each individual resident, their relative and care needs...He leads by example".

At our previous inspection of 22, 26 and 28 October 2015 we found the registered manager had failed to implement robust quality assurance systems to assess, monitor and improve the quality and safety of the home. Where risks to the quality and safety of the service people received were identified measures were not in place to ensure these were mitigated and addressed. Care records did not always accurately reflect the care and treatment provided to the person including the decisions taken in relation to the care provided.

Following the previous inspection the registered manager had reviewed their auditing processes with nurses regarding the completion of people's care documentation. We could see this had resulted in a positive improvement in the completion of such documentation and working practices. However, there were still areas where this work had not been completed fully and we could see care plans had not yet all been updated fully. People's MCA assessments had not always been completed and some people's care plans were missing information regarding their spiritual needs. The registered manager was in the process of moving all care records from paper based to being stored, accessed and reviewed on a computer system. This had caused a delay in some documentation being reviewed to ensure it remained accurate and contained all the relevant information staff needed in order to provide care and support. Whilst action had been taken and we had seen an improvement, more time was needed to ensure the work was completed fully and that the changes made in documentation completion were accurate, embedded in working practices and sustained.

The registered manager wanted to promote a positive culture which was person centred, (this is where care and support is highly individualised to the person) and open amongst staff and people living at the home. They wanted staff to be able to speak openly and honestly with them and had worked hard in order to promote this feeling amongst staff. This open and honest culture was felt by staff who agreed that they would be able to raise any concerns they had with the registered manager and feel they would be listened to with action being taken when appropriate. One member of staff told us, "Definitely, I've got no worries about doing that (raising concerns with the registered manager)".

The registered manager promoted their availability to people and their ability to provide support whenever required. Relatives confirmed they were able to raise any concerns at any time with the registered manager. One relative told us, "Think having the manager/owner on site is useful, he is a knowledgeable person". Another relative told us, "(the registered manager) is quite laid back but he has his merits". Relatives told us

they could always speak to the registered manager if required and were confident that action would be taken if they raised any concerns. Staff felt that they were subject to consistent and valued support from the registered manager. We asked staff if they thought the home was well led by strong managerial support. One staff member told us, "The manager is very approachable and will always respond to a question". Another member of staff said, "He's (the registered manager) nice, really nice, he's involved a lot – if we're running late in the morning he'll come and help, he mucks in with everything".

The registered manager wished to promote a homely environment at Eastfield. The home had a 'Philosophy of Care' which was openly available to people in the introductory pack they received when they moved to the home. This stated the home's philosophy of care was, 'To treat everyone with respect and dignity'. Following this statement were the principles that the home was committed to achieving to ensure people's physical and emotional wellbeing needs were met whilst living at the home. These included; providing a welcoming and supportive environment, people being assisted to maintain their independence, people would be cared for in a dignified and respectful manner and individualised care agreed with people and their relatives would be provided in a private and comfortable environment.

Most people and relatives we spoke with confirmed these values were displayed by the staff during the delivery of their care and felt the home provided a homely environment. One person told us "(the atmosphere is) fairly happy, it's pleasant here", another person agreed there was a pleasant atmosphere at the home. A relative told us, "I think it's a happy atmosphere (at the home) and the staff interact well with the residents…it's generally happy…I think it's a cheerful environment". Another relative said, "It's very friendly here".

Prior to the inspection it had not always been clear the registered manager had understood all their responsibilities in relation to their registration with the Care Quality Commission (CQC). It had not always been clear that they had submitted all the relevant notifications to the CQC, in a timely manner, about any events or incidents they were required by law to tell us about. For example, prior to the inspection an incident had been reported to the emergency services however the CQC had not been notified as required. This had been addressed and the registered manager was now aware of all aspects of their requirements and was submitting their notifications in a timely and accurate fashion.

People and their relatives were actively encouraged to be involved in developing the service. The registered manager sought feedback from people to identify how the service people received could be improved. This occurred during care reviews and a biannually completed quality questionnaire survey. The last published annual quality questionnaire survey had been completed in November 2016 with the results made available in January 2017. These questionnaires asked for feedback in key areas such as people's satisfaction with the quality of the care provided, the positive and negative aspects of living at Eastfield and asked for suggestions on how the service could improve.

As a result of the feedback received during this process the registered manager had created an annual development plan which addressed the areas for improvement noted during this feedback process. From here actions had been identified and a timescale given for completion. For example, during the survey it had been commented that there should be more encouragement for people to take part in activities. As a direct result the registered manager had developed their activity programme to meet people's needs which included the provision of more external events and shopping trips. It was documented that more trips would be integrated into the activities programme by February 2017 and we could see that this was happening. It had also been identified that communication with relatives could be improved when they were not always able to visit. The registered manager acknowledged the need for hosting relatives meetings to as a way of obtaining feedback and was due to hold their first meeting following the inspection. These had been held

previously however, were not always well attended so had stopped. However, the registered manager was keen to respond to feedback and was restarting these to provide an additional opportunity to increase communication with the family and friends of those living at the home.

There a system in place to monitor the quality of the service people received through the use of regular staff and registered manager audits as well as daily observations of staff in their role. The nurses conducted a number of audits on a regular basis which included daily, weekly and monthly checks as part of their role. For example, nurses were required to complete daily checks of the general health of people living at the home, wounds dressings and management, supervision of staff for example. These were followed by weekly auditing of drugs and monthly reviews of the infection control audit, falls, audit and MARS checks. The registered manager also completed infection control and health and safety audits to ensure the ongoing quality of the service provided. Following these audits action plans were put in place which detailed any actions needed and prioritized timescales for any work to be completed. For example, during the last Health and Safety audit in 2016 it was identified that specific risk assessments were required to be put in place for specific activities that were not covered in an overall general risk assessment. It was deemed that this action required completing by September 2017. This action had been completed and we saw specific risk assessments were in place regarding people's use of the swimming/hydrotherapy pool for example. The registered manager ensured through the use of regular monitoring areas which required improvement were identified and timely action taken to continue to improve the quality of the service people received.

Compliments had also been received in the home which identified where they believed high quality care had been provided to their loved ones. During the last completed quality questionnaire survey we saw people spoke positively of the care provided at the home, people had provided comments including, 'Nursing care is very good', 'Staff friendly, welcoming and attentive', 'My father says that the home is like a home' and 'Staff and management very approachable'. We also viewed a selection of cards and letters which had been received at the home. One relative had written 'Many thanks for the kindness shown to our wife and mother', Another had written, 'Thank you for all your help and support for me staying at Eastfields' and another read 'To all the staff at Eastfield, thank you for your care of (family member), he said everyone was very kind and caring…thank you and your staff for all the care that you gave to (family member), he loved to chat and attend the activities that (activities coordinator) organised'.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered manager had not ensured they had always sought appropriate consent prior to the use of items which restricted people's liberty. This was a continuing breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.