Voyage 1 Limited

Cote House

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Cote House is a residential care home providing personal and nursing care for up to 11 people. 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.

The inspection took place on 11 January 2018 and was unannounced. The service did not have a registered manager; the previous registered manager had recently resigned and was overseeing the service two days per week until a new manager commenced employment. 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.

Staff had not received training in all aspects of their roles and had not had regular supervision sessions with their supervisor. This meant staff's performance in their role was not regularly monitored and training and development needs were not always being identified.

People were supported to contribute to decisions about their care and were involved wherever possible. Whilst we saw some positive interactions we observed that these were not consistent throughout the day. Staff did not always treat people with dignity and respect.

People and their relatives did not speak positively about the activities available. Staff we spoke with told us there wasn't always time to support people with activities.

There were robust recruitment practices in place that protected people from being cared for by unsuitable staff. However, staff did not feel sufficient numbers of trained and experienced staff were deployed to ensure people's needs were met.

The acting manager was working two days per week and there was no deputy manager in post. This meant that on the other five days of the week there was a lack of leadership and a lack of managerial oversight of the service. Three notifications had not been sent to the Commission as legally required to inform of significant events such as potential safeguarding alerts. Provider quality assurance audits had been completed, but issues arising from these had not been addressed despite the audits taking place seven months prior to our inspection.

Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents and concerns. Staff we spoke with said they felt confident to raise concerns and that action would be taken to address these.

People said they had access to external health care professionals when required and the GP would visit if

needed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff were aware of their responsibilities in relation to safeguarding people from avoidable harm and abuse, but notifications were not always made to the commission.

Care plans contained risk assessments and plans guided staff on how to minimise risks to people.

Medicines were not always managed safely. Medicine incidents had not always been reported.

Staff recruitment procedures were robust

Is the service effective?

Requires Improvement

The service was not always effective.

There were significant gaps in staff training.

Staff were not supported through regular supervision.

People were supported to access sufficient food and fluid. Menus were planned four weeks in advance which did not show a person centred approach to meal planning.

Is the service caring?

Requires Improvement

The service was not always caring.

Lunchtime was not a positive experience for people using the service.

We saw examples where people had no verbal interaction with staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were person-centred; however daily records were task

focussed.

Monthly key worker reviews were repetitive and there was no evidence that people's feedback had been taken into consideration.

People did not have access to activities that met their social needs.

Is the service well-led?

Requires Improvement

The service was not well-led

Staff spoke positively about the support they received.

Safeguarding notifications had not always been sent to the commission.

Medicine incidents had not always been reported through the provider's incident reporting system.

Issues that had been raised during provider audits had not been addressed.

Cote House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 11 January 2018 and was unannounced. The inspection was carried out by two inspectors. The previous inspection took place on 21 September 2015 and was rated Good.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we had about the service including statutory notifications. Notifications are information about specific events that the service is legally required to send us.

During the inspection we spoke with three people living at the home, three staff members, the acting manager and the operational manager. We also received feedback from health professionals that visit the service regularly. After the inspection we spoke by telephone with three relatives and one other person living at the home. We reviewed four people's care and support records and three staff files. We also looked at records relating to the management of the service such as incident and accident records, meeting minutes, recruitment and training records, policies, audits and complaints.

Requires Improvement

Is the service safe?

Our findings

The staff we spoke with were aware of the processes they would follow should they suspect abuse was taking place or a person was at risk of harm. Staff told us they had received training in safeguarding and all demonstrated that they knew how to report any concerns. Staff we spoke with said they felt confident to raise concerns and that action would be taken to address these. Staff were aware of outside agencies they could contact such as the local authority and the Care Quality Commission if they needed.

Staff comments included "Part of safeguarding is being aware of how you are supporting people. Signs of abuse might be if some has bruising or unexplained marks. I would observe for mood changes and if I was concerned I would feel comfortable reporting this to the manager or the nurse" and "Our training covered the different types of abuse and the signs to look for. The signs I would look for would be bruising or if the person became withdrawn. Any concerns would be reported to the nurse. I would feel that they would listen and take some action. They are very good here."

However, although staff were aware of the processes for reporting concerns, safeguarding notifications were not being made to the Commission appropriately. Therefore, we could not be assured that the systems in place were robust enough to protect people from avoidable harm or abuse.

Care plans contained risk assessments for areas such as falls, mobility, malnutrition and skin integrity. These had been reviewed monthly. When risks were identified, the care plans provided clear guidance for staff on how to reduce the risks of harm to people. For example, when people required the use of equipment to move safely, details of how to do this were provided. Staff were aware of risk assessments and knew how to refer to the guidance within them to keep people safe.

The building and equipment was checked and maintained to keep people safe. For example, we looked at completed fire safety reviews, ceiling hoist checks and the gas safety report.

During the inspection there were appropriate numbers of staff on duty. There was one nurse and four healthcare assistants on duty to support eight people. Staff were visible and call bells were answered in a timely manner. However, staff we spoke with said that staffing levels were not always appropriate. Their comments included
"Whilst people always get care we feel under pressure to get it done. Sometimes I feel rushed. Cover is generally sought from agency. When we are short staffed it is difficult to offer shadowing opportunities to new staff members" and "Staffing is an issue with people who need 1:1 and people on respite. We do not have any additional staffing for people who are on respite. Care gets done but activities suffer. Some days are better than others. There isn't always time to spend with people who are in their rooms."

There were mixed comments from people and their relatives about staffing levels. Their comments included "There are always enough staff. Always someone to help", "Staff are very busy. I have to be patient and wait for care. I know I am not the only person they have to help", "The care is adequate. They are good at

answering when I press my buzzer. They don't have time to sit and chat" and "There never seems to be enough staff to do activities. They always seem to be doing paperwork during our visits." One person using the service said "I should be having 1:1 for rehabilitation, but it hasn't happened. Staff say they'll do it when they have time, but it never seems to happen."

People and their relatives said care provided kept people safe. Their comments included "Yes staff keep me safe. When they transfer me they offer me reassurance and that makes me feel safe. They check if I am happy" and "I always have two staff when they are hoisting me. I feel safe with that. They hold my legs to make sure they are not dangling. They do offer me reassurance." One person did tell us they did not feel safe in the shower as they felt the commode was too high and staff did not offer any reassurance. However, one person told us "I don't always feel safe. I feel that some of the staff aren't strong enough when they move me." They said they had raised their concerns with the acting manager.

Medicines were not always managed safely. We looked at medicine administration records (MARs) and saw that all had been signed to indicate people received their medicines on time and as prescribed. Stock levels of medicines were checked regularly. Medicines were stored safely, including those that required additional storage requirements. The temperature of the clinical room and the medicines fridge was monitored. People's preferences in relation to how they preferred to take their medicines had been recorded. For medicine that was prescribed for use when required (PRN), we saw protocols were in place and detailed when people might need additional medicines and the reasons why. Staff responsible for administering medicines had their competency to do so assessed annually. The staff competencies we looked at showed that staff had all been assessed within the previous 12 months.

Incidents and accidents were reported. However, no medicine incidents had been reported. This was despite a note at the front of the MAR charts reminding staff to sign the charts because there had previously been some missed signatures. Additionally, there was a note informing staff that one person had missed a dose of one of their medicines on three consecutive days, but this had not been reported as a medicine incident. One person using the service said "They ran out of my medicine once, which doesn't give me much confidence." We discussed this with the Acting Manager during our inspection and they said they would resolve this.

Safe recruitment practices were followed. We looked at three staff files and saw that necessary checks and references were sought prior to employment

The building was clean and tidy and smelt fresh. Staff had access to personal protective equipment such as gloves and aprons and these were readily available. "Cleanliness checks" had been completed. We looked at the last one dated 2 September 2017. Although no issues had arisen, the providers Infection Control policy did specify that these audits should be undertaken on a monthly basis. However, records showed these had been completed five times during 2017 rather than 12 times.

Requires Improvement

Is the service effective?

Our findings

Staff did not receive supervision in line with the provider's policy timeframes to support them in delivering effective care. Supervision is where staff meet with their line manager to discuss their performance and development. The provider's policy stated that staff should receive supervision a minimum of four times a year. The supervision matrix we reviewed showed 34 members of staff were overdue a supervision and of those, 15 had not had a supervision for at least six months. This meant staff's performance in their role was not regularly being monitored and training and development needs were not being identified. Whilst staff said they had access to appropriate training one staff member told us "As we are supporting new staff going through induction we are getting a bit behind with our training as we don't have the time to complete it. We are struggling to complete our refresher training." Another member of staff said that they received a thorough induction and been afforded the time to complete the necessary core training as required by the provider.

Although staff said they felt supported their comments included "It's a bit messy not having a full time manager. I get plenty of day to day informal support but I am not receiving regular one to one meetings. I feel supported daily but do not feel my overall personal development is supported." Another staff member told us "Whilst I can go to the nurses for support there is a real lack of management in the home." The acting manager said "We are well behind, but we are starting to address it. We've arranged some group supervision for staff with the option of one to one if they want it."

We reviewed the staff training records and saw that staff received training in areas such as fluid and nutrition, infection control and safeguarding. Nurses said they had access to ongoing professional development in order to meet their registration requirements. One said "We have links with the local hospice and have regular updates." However, overall compliance against the provider's training requirements was only 69%. Eight staff were overdue refresher training in the Mental Capacity Act and Deprivation of Liberty safeguards and eight other staff had not completed it at all. 19 staff had not completed Privacy and Dignity training and 16 staff had not completed training on how to provide person centred care. 18 staff were overdue updates in the management of actual and potential aggression. This meant that staff had not been given the opportunity to maintain their skills and knowledge. One person using the service said "I don't think the training is specialist enough."

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

People were supported to access sufficient food and fluid throughout our inspection. Comments from people and their relatives about the food provided were not always positive and included "Whilst the meals are home cooked there is not a great deal of variety. From our experience the meals are not very nutritious and are lacking in fresh vegetables", "Food is pretty good. Some meals are better than others. It's pretty rare we have a meal I don't like. I can choose something else if I don't like the meal. They will go out of their way to give you something" and "The food is not bad but there isn't much variety. There's not much choice". Other comments included "I was asked about my food choices, but the evening meal is always stuff I don't

like. I know they have to cater to lots of needs, but I feel more thought should go into the planning."

The service worked closely with other organisations to deliver effective care and treatment. Feedback from health professionals included "Cote House were keen to have a handover from all the staff working with my patient and they were also keen to have further training from my team, so I provided them with contact details. They also ensured that they would provide transport to pre-arranged appointments in hospital" and "(The team) will, where appropriate have multi-disciplinary meetings to discuss with relevant care professionals, client, family member etc. the needs of a particular patient." People said they had access to health care as necessary and the GP would visit if needed. They said they could access pain relief in between their regular medicines to ensure they were comfortable. One person told us "I could tell the nurse if I was not well. I go to my appointments and check-ups and needed." Another person told us "They have recently supported me to attend the opticians and have my blood test." Staff said any concerns with people's well-being were reported to the nurse. They said that where required, they attended hospital appointments with people.

The provider had met their responsibilities with regard to the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). One person using the service was subject to a DoLS authorisation. Although this had expired, we saw that the acting manager had sought a reassessment from the local DoLS team.

The staff we spoke with demonstrated an understanding of the Mental Capacity Act 2005 despite records indicating that not all staff were up to date with their training. They explained how they supported people to be involved in choices about their day to day living. Staff comments included "It's about people's capacity to make choices even if they are seen to be unwise choices. For example, one person chooses not to have their lap strap on in the home. They know the difference between not wearing it in the house and the need to wear it outside for safety. We need to make sure what we are doing is the least restrictive. People are involved in daily choices such as their food and what activities they want to do" and "People have the capacity here to be involved in their care. They have a monthly meeting with their keyworker to go through things like their activities, concerns they may have and any changes they want to make. People are involved in choosing what food they want to eat, clothes they want to wear and if they want to do any activities."

People told us that staff sought permission before undertaking any care tasks. However, we did not observe this consistently throughout our visit. For example, one person had their sling adjusted by a staff member. The staff member did not approach them and ask if this was alright to do so. Another person had a cover put round them without staff asking if they wished to wear one.

Requires Improvement

Is the service caring?

Our findings

Whilst we saw some positive interactions we observed that these were not consistent throughout the day. We observed the lunchtime meal during our inspection and found it was not a positive experience. People were supported to access the dining room. Music was playing but staff did not ask if people wished to have the music on or what music they would like to listen to. People were not asked what they would like for their meal. They were not asked if they wanted all the vegetables available or if they would like gravy on their meal. Everything was put on people's plates. Meals were placed in front of people without staff explaining what was on the plate. One person who was visually impaired was not told what was on their plate or where each food was positioned so they could know what they were eating.

Staff assisted people who needed support. However, staff did not sit by people during this support and stood over them, occasionally going between people to offer support. We observed one member of staff stood over someone whilst assisting them with their lunch. The staff member did not engage in any conversation with the person whilst supporting them to eat their lunch. Both of these instances demonstrated a lack of respect for the people they were supporting.

Staff who were not supporting people with their lunch stood in the kitchen and dining room doorways. They engaged other members of staff in conversation but did not always include the people eating their lunch. Staff spoke about one person who was staying away from the home in front of other people. This did not respect the person's confidentiality.

During the morning of our inspection we overheard one member of staff who was supporting one person ask another person in a loud voice if they wished to go to the toilet. This was not done discreetly and did not respect the person's right to privacy.

We spoke with one person about their care needs. They said personal care "Was not a pleasant experience" and said they "Dreaded" seeing the shower chair being pushed in to their room. We asked why they were showered and they responded they did not know and would prefer a bath. This was reflected in their care plan. However, when we spoke with staff they said this person had never been in the bath to their knowledge. They said in general the person did not like personal care. We reviewed this person's daily records and there was no record of how they were responding to personal care and if this was a negative experience for them. There were records of where the person had refused personal care but no reasons why or what alternatives had been offered. The person gave us permission to raise this with the manager so they could look to resolve this situation which they agreed to do.

Another person said "I don't have appropriate hoisting facilities. I don't fit in the bath, and I don't fit in the shower chair. I've had a few baths, but I have to have my legs hanging out." We discussed this with the Operations Manager after the inspection and they said they were working with the occupational therapist to source appropriate equipment for this person.

One person had a hearing impairment and their care plan stated that staff should make the person aware

they were speaking to them. This included standing in front of the person. We observed one staff member standing behind the person trying to explain to them they were alright to leave the dining area. The person said they could not hear the staff member but they still did not move in front of them. Another member of staff then moved in to their field of vision to explain.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives generally spoke positively about staff. Their comments included "Staff are lovely. They know [person] very well. The nursing staff are brilliant. They are a wonderful bunch of people", "Staff are very friendly and nice", "The staff are friendly. Very good in being helpful. Any advice I need and they will help me." One person told us "Some staff are nice but some staff don't speak at all. Some staff can be quite stroppy. There are lots of new staff who don't know me very well".

People were supported to contribute to decisions about their care and were involved wherever possible. For example, people had regular individual meetings to review how their care was going and whether any changes were needed. Details of these meetings were recorded. However, these were repetitive and did not show that previous feedback from people was considered or used to change elements of the service. For example, in the review for one person in April 2017 it had been documented "Doesn't enjoy fish, new curries would be nice". The same statement had been written in all subsequent reviews, but there was nothing documented to show what, if anything, staff had done to address the person's comments.

Staff all spoke about wanting to provide people with a good standard of care. They were able to explain how they promoted people's dignity whilst respecting their privacy by ensuring they communicated what they were doing with people and ensuring personal care took place behind closed doors. One staff member told us "I try to make sure people are not uncomfortable with me providing personal care. I check things are ok. I always make sure doors are closed and people are covered whilst I am supporting them." However, one person said "I don't think some of the staff care. It's just a job to them" and "I've had young female staff saying they feel uncomfortable giving me personal care. But I feel my loss of dignity more than them".

Staff said they were respectful of people's diverse social, cultural and spiritual needs. Staff told us it was important to treat people as individuals. One member of staff told us "People's diverse needs are reflected in their care plans. People are able to choose if they prefer a male or female care to support them and their wishes are respected. You have to respect that people's choices are not all the same and support this."

Despite what staff said, during our observations we did not always see their comments put into practice when interacting with people.

People were supported to meet their cultural needs. A member of the church visited those people who wished to practice their religion and were unable to attend the local church.

People were supported to maintain relationships with their family and friends. Relatives we spoke with said they could visit Cote House anytime they wished. People's bedrooms were personalised. People were surrounded by items within their rooms that were important and meaningful to them. This included such items as furniture, ornaments and photographs.

Requires Improvement

Is the service responsive?

Our findings

Care plans were person centred. There was a large amount of detail recorded about people's preferences and choices in relation to how they wanted to be supported. For example, care plans contained information on a person's typical day, noting if they woke up independently and what support they required. The plans also noted if people preferred to receive their support from a female carer only and their preference around showering or bathing. People's routines recorded the support they required with such things as personal care, dressing, skin integrity and mobility.

Wound care plans were not comprehensive. We looked at the plan for one person with a wound. The tissue viability nurse had reviewed the person and suggested a wound dressing plan. Although this was written within the general plan, there were no photographs of the wound. This meant it was difficult for staff to assess whether the wound was improving or deteriorating. Additionally, because there was no separate wound plan, staff had documented in different sections of the care plan when the wound had been assessed and redressed. The information was not clear and was not easy to access. We discussed this with the acting manager during the inspection and they said they would address this at the earliest opportunity.

We recommend that a review of wound documentation takes place to ensure that the information is accurate, up to date and is easily accessible to staff

Care plans had been regularly reviewed and had been updated when people's needs changed. Care plans we looked at contained evidence that people or their advocates had been actively involved in writing the care plans or in the reviews

Daily records of support and care provided were not person centred and did not demonstrate that people were offered choices throughout the day. Instead they were written in a task focussed way. For example, the daily records for one person for the ten days prior to our inspection, showed that every day except one, the person had "watched TV in the lounge" There was nothing documented to show that the person had been offered an alternative activity. This had been highlighted during the last provider quality audit in May 2017. The audit report stated "There is no evidence within monthly workbooks/daily recordings that people are offered choices and are making decisions every day".

Staff did not always demonstrate an understanding of what "person centred" care meant. For example, one staff member described it as "We take people out, provide activities and make sure people aren't just sat in their rooms." One person using the service said "I don't think I get person centred care. Although the staff are very nice I don't think my preferences are always considered."

There was no formal activities provision in place. The acting manager said that activities were provided in accordance with people's wishes. One person had access to their own vehicle and often went on trips. The service was waiting for delivery of a minibus, which would mean that other people could go out on trips more frequently, rather than having to rely on the local taxi service. The lack of activities had been highlighted during a staff meeting in September 2017 when it had been documented "Aim to get a working

activities programme in place" and "Aim to complete by end of October 2017". However, this had not happened.

People and their relatives did not speak positively about the activities available. Their comments included "There is never much going on when we visit. Staff always seem to be just doing paperwork. I don't feel the staff have the right skills to be able to provide activities", "I am not aware that [person] has any social stimulation. They quite often refuse to do anything but it would be nice if staff could spend more time with them and take them out", "There isn't a lot to do. I miss having conversations with people. Staff never have the chance to sit and have a conversation with you" and "Activities depend on the day. I choose what I want to do." One person "I don't know what is happening. They never come and ask me. Staff don't spend time with me just chatting." Another person said "Occupying my time in a meaningful way is important to me. My emotional needs are very important."

Staff we spoke with told us there wasn't always time to support people with activities. One staff member told us "There is no timetable of activities in place. We just ask people each day. There is not always time to do activities and people's presence in the community is limited." Another member of staff said "It is difficult to find transport to access the community. We are supposed to be getting a new bus to help this. There is no activity programme. People have different interest which can make it difficult to provide activities. We do sometimes have outside people come in and do things, like manicures or music."

We sat in the communal lounge area during the afternoon. One person was in there listening to music. Staff walked through the lounge and did not engage with the person to check they were still happy with the music. Between 14:20pm and 14:40pm staffing walking through the lounge, including new staff coming on duty did not speak to the person or greet them. At 14:40pm one member of staff approached the person to introduce themselves and to seek permission to check the person's dressing. The next time staff interacted with this person was at 15:20pm when a member of staff approached the person and asked them if they'd had a good day. Staff did not ask if the person wanted to participate in any other activities such as being read to which it was noted they enjoyed doing in their care plan.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a complaints policy in place. Complaints and concerns were reported and investigated appropriately. Compliments had also been received, such as "Thank you for the excellent care" and "The team made me feel so welcome; they provided exactly the support I needed for my placement." People and their relatives told us that they felt able to raise any concerns or issues. They told us they felt confident they would be listened to and actions would be taken as appropriate to resolve any concerns they may have. Their comments included "They check if I am happy. I have a regular meeting every three to four weeks to talk about the day to day things and to see if I am happy", "I don't know how to make a complaint but I could talk to staff" and "I can raise my concerns with the staff or manager. However even though I have raised some concerns I still feel that some staff are not always understanding of my relative's needs." One person said "I have raised concerns with the manager, but I'm waiting to see the results."

Staff explained that if anyone required end of life care then they would follow the guidance provided by nursing staff. They felt people would be supported to express their views on how they would wished to receive this care where required. One relative told us they and their family member had been involved in discussion about how they wanted end of life care to be provided. This included the person being able to remain at Cote House and receiving care from the nursing staff who they were familiar with.

Requires Improvement

Is the service well-led?

Our findings

The previous registered manager had resigned from their post and was "overseeing" the service two days per week. There was no deputy manager in post at the time of our inspection. However, a new manager and a new deputy manager were both due to commence employment in the coming weeks. The lack of a full time manager meant there was a subsequent lack of visible leadership on a day to day basis and that improvements to the service had not been implemented or identified. Regular supervisions were not being undertaken to monitor the attitudes, values and behaviour of staff. There were gaps in the training that had been provided to staff meaning that staff were not trained and supported in their roles.

Notifications had not always been submitted to the Commission as required. Notifications are information about specific events that the service is legally required to send us. We saw three examples of incidents that should have been notified to us, although they had been referred to the local safeguarding team.

Although audits were undertaken, and action plans devised to address issues, these had not always been completed. For example, the latest provider quality audit was dated May 2017. In this audit it had been noted "There is no evidence within monthly workbooks/daily recordings that people are offered choices and are making decisions every day" and "All staff to be supported to evidence choices that are being offered through training/supervision/handover". The action had not been signed as completed.

A lack of activities had been highlighted during a staff meeting in September 2017 when it had been documented "Aim to get a working activities programme in place" and "Aim to complete by end of October 2017". However, this had not taken place.

Medicines incidents had not always been reported. The acting manager said "I know things have slipped a bit."

Staff were aware of the vision and values of the organisation. Their comments included "We are here to provide people with good levels of care and promote their dignity" and "We are here for the client's welfare and to provide person centred care." On the day of the inspection, however we did not see these visions and values put into practise by staff.

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

Staff spoke positively about working at Cote House. Their comments included "It's a very nice place to work. There is nice support from the team. We are a family orientated service" and "I enjoy working here and getting to know people."

The service worked in partnership with other agencies to meet the needs of people using the service. Feedback from health professionals was positive in relation to the manager. Comments included "The

manager was very approachable when she came to visit my patient. She took on board my advice on how best to communicate with him, and made him feel at ease" and "The manager who has just officially left but still has a presence until a new manager is in post, is/was to my mind a very efficient and dedicated member of staff."

Feedback was sought from people using the service during monthly key worker meetings; however there was nothing to demonstrate that people's feedback had been considered to improve the menu choices for example.

Staff meetings took place; however, actions arising from these meetings had not been implemented, such as the development of a meaningful programme of activities.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 (1) (a) (b) (c). People did not receive care and treatment that was appropriate, that met their individual needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (2) (a) (b). The lack of managerial oversight did not ensure that the service was assessed, monitored and improvements implemented to improve the quality and safety of care and support.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 (2) (a). Staff had not received updated training to ensure that they had the qualifications and skills to complete their role.