Completelink Limited

Prestwood Coach 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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 21 November 2017 and was unannounced. Prestwood Coach House is a care home that provided accommodation and personal care. It is registered to accommodate 40 people in one building. Some of the people living in the home are living with dementia. At the time of our inspection 31 people were using the service. Prestwood Coach House accommodates people in one building and support is provided on two floors. There is a communal lounge and dining area, a conservatory and a garden area that people can access.

The service had a registered manager in post. 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.

When we completed our previous inspection on 22 October 2015, the service was rated as good overall. We rated the well led domain as requires improvement as we found there was a lack of confidence that concerns raised would be dealt with and people did not always know who the registered manager was. Quality checks were in place but did not always bring about change.

At this inspection we found staff did not always feel listened to and when they raised concerns they felt action was not always taken. People did not always know how to complain and people did not know who the registered manager was. There were quality monitoring systems in place however they did not drive improvements within the service. The provider did not always notify us of significant events that had occurred within the home.

Risks to people were not always managed in a safe way and assessments were not always reviewed to reflect people's current needs. There were not always enough staff available for people and they had to wait for support. The provider did not assess people's dependency levels within the home to ensure there were enough staff available. Referrals to health professionals were not always made in a timely manner. When professionals had made recommendation these were not always followed placing some people at risk. Infection control procedures were not always effectively implemented within the home, increasing the risk of cross infection for people.

Care plans and risk assessments were not always reviewed to reflect people's current needs. People preferences or cultural needs had not always been fully considered. When people lacked capacity to consent this was often unclear and we could not see how decisions were made in peoples best interests. People were being unlawfully restricted as authorisation for DoLS had not been considered. There was lack of understanding from both staff and the registered manager with regards to this. Therefore people are not supported to have maximum choice and control of their lives and staff do not support them in the least restrictive way possible; the policies and systems in the service do not support this practice.

People were happy with the staff and people were treated in a kind and caring way. People were encouraged to be independent and make choices about their day. People enjoyed the food and were offered a choice. They also had the opportunity to participate in activities they enjoyed. People were supported to attend health appointments when needed. Medicines were managed in a safe way. Advanced decisions had been considered for people and end of life care had been anticipated by the provider.

Staff understood when people were at harm and to report safeguarding concerns. The provider had a system in place to ensure staffs suitability to work with the service. The provider sought feedback from people and relatives. When formal complaints and been made the provider had responded to these in line with their procedures and people were happy with the outcome. The provider ensured there was enough protective personal equipment available for people. Staff received an induction and training that helped them support people. The provider worked alongside other agencies and they were displaying their previous rating in line with our requirements.

This is the first time the service has been rated Requires Improvement. We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.
Risks were not always reviewed or managed in a safe way. There was not always enough staff available for people and they had to wait for support. Staff understood when people were at harm and how to report this; however when safeguarding incidents had occurred we could not see how lessons had been learnt. Infections control procedures were in pace however they were not always followed. Medicines were managed in a safe way. The provider ensured staff suitability to work within the home.

Is the service effective?

Requires Improvement

The service was not always effective.
It was unclear when people lacked capacity to make decisions for themselves and when needed decisions had not always been made in people's best interest. People were unlawfully being restricted and this had not been considered. Referrals to partner agencies were not always made in a timely manner. Concerns were raised around the training and induction of agency staff. People enjoyed the food and were offered a choice. People attended health appointments. There was up to date legislation available for staff to follow. Permanent staff received training that helped them support people.

Is the service caring?

Good

The service is caring.
People are happy with the staff and were supported in a kind and caring way. People made choices about their day and were encouraged to be independent. Family and friends felt welcomed and were free to visit throughout the day. People's privacy was respected and dignity upheld when they received care.

Is the service responsive?

Requires Improvement

The service was not always responsive.
People did not always receive care in their preferred way. Care plans were not always reviewed to reflect people's needs and when people had cultural needs these had not always been fully considered. People were not always sure how to make a

complaint. When formal complaints had been made the provider had responded to these in line with their procedures. People had the opportunity to participate in activities they enjoyed. End of life care had been considered for people.

Is the service well-led?

Requires Improvement

The service was not always well led.
Staff did not feel listened to and when needed action was not always taken. People and relatives did not always know who the registered manager was. Quality checks did not always drive improvement within the service. The provider sought feedback from people and relatives. The provider was displaying their rating in line with our requirements.

Prestwood Coach 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.

Prestwood Coach House is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Prestwood Coach House is registered to accommodate 40 people in one building. Some of the people living in the home are living with dementia. At the time of our inspection 31 people were using the service. Prestwood Coach House accommodates people in one building and support is provided on two floors. There is a communal lounge and dining area, a conservatory and a garden area that people can access.

This inspection visit took place on the 21 November 2017 and was unannounced. The inspection visit was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The inspection was informed by feedback we had received from the public through 'share your experience' and notifications the provider had sent to us about significant events at the service. We used this to formulate our inspection plan. We reviewed the draft quality monitoring report that the local authority had sent to us.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spent time observing care and support in the communal areas. We observed how staff interacted with people who used the service. We spoke with seven people who used the service and four relatives. We also spoke with three members of care staff, three registered nurses and two activity coordinators. We did this to gain people's views about the care and to check that standards of care were being met. Two of the providers

were also present for feedback along with the registered manager who is also one of the providers.

We looked at the care records for ten people. We checked that the care they received matched the information in their records. We also looked at records relating to the management of the service, including quality checks and staff files.

Requires Improvement

Is the service safe?

Our findings

Risks to people were not always managed in a safe way. For example, we saw documented for one person they should receive a folk mashable diet, due to their risk of choking. This was in line with recommendations made by a speech and language therapist (SALT). When we spoke with staff they were aware of this and confirmed this to us. At lunch time we observed that this person was supported to eat food that was not in line with these recommendations, meaning food that had not been mashed. Furthermore, later we observed they were eating a digestive biscuit again this was not in line with recommendation made; they were also unsupported whilst eating this. This meant as this person had not received the correct diet they were placed at an increased risk of choking. We raised our concerns with the providers about this.

Staff told us another person was at high risk of choking. We checked the records for this person and there was no risk assessment in place, even though a recent episode had been documented where the person had needed first aid following an incident. We saw there were recommendations made in 2016 from SALT. These included, 'assistance with diet and fluids'. At lunchtime we observed that this person ate their meal independently and was not supported or observed by staff as recommended, as needed.

We saw plans were in place to respond to emergencies. These plans provided guidance and information on the levels of support people would need to be evacuated from the home in an emergency situation. However when people's needs had changed they had not always been reviewed or updated to reflect this. For example, one person mobility had deteriorated and it was recorded in their care plan that they 'often require a wheelchair', to mobilise. The information recorded in the emergency plan stated, 'mobile with one carer'. This demonstrated risk assessments were not always reviewed to reflect people's needs.

There were procedures in place to manage infection control with the home. However, we could not be assured these were always effectively implemented. For example, we observed two people were transferred using the same sling. People using the same sling increases the risk of cross infection. We spoke with staff who confirmed that not all people living at the home had their own sling. One staff member said, "There is only one person who has their own sling, the others share". We spoke with one of the providers who confirmed there were enough slings available for people. Staff also told us, due to the pressures they were under they could not be sure commodes were always cleaned as effectively as they should be, increasing the risk of cross infection. One staff member said, "We move them from room to room, if someone is waiting and has been waiting a while, we can just give it a quick wipe". This demonstrated infection control procedures were not always followed.

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

There were not always enough staff available for people. One person told us, "The girls are wonderful but they are rushed off their feet. The buzzers go like crazy after six in the morning". Another person told us, "They could do with an extra couple of staff they are so busy and there are some demanding people". A relative said, "Occasionally they have to wait when they use the buzzer, staff can't be in two places at once

and my relation needs two carers". We saw that people had to wait for support from staff. For example, at 11:50 we saw staff were supporting the last person to get up that morning. Staff confirmed to us they were not able to offer support to this person earlier as they were supporting other people. The person was unable to tell us about their experience of this. Another person told us they liked to get up around 09:45; we saw that this person was supported to get up at 11:00. They told us, "I wasn't up until eleven this morning and ideally like to be up about nine forty five". We spoke with staff about this. One staff member of staff said, "There are just too many people and not enough staff". They went on to say, "On a good day we can get everyone up by about 11:00 but that's still late when people have asked to get up at 08:30".

At lunchtime we saw that people did not receive the support they needed. For example, we observed that five people were supported by one staff member. All the people were sat in a row next to each other. The staff member went from person to person offering support, whilst standing. They went to one person and offered them a spoonful of their meal before moving on to the next person, once they had offered the fifth person some of their meal; they would then go back to the first person. We observed people looking at the staff member and when the staff member walked past we observed a person opening their mouth and gesturing they were ready for some more. This demonstrated when people needed support from staff to eat their meals they had to wait.

We reviewed the information the provider had sent in the PIR. This stated, 'Robust system are in place to ensure that staff to clients ratios are good and that resources are on hand or sourced if required'. We spoke with the registered manager who confirmed there was no dependency tool in place and that people's individual dependency levels were not assessed. Staff raised concerns about people's dependency levels within the home. One staff member said, "The manager and directors tell us there are enough staff, however people's dependency levels have changed and that's not considered. We have people who used to need one staff for support and now need two. We have others who need one person to help them but six months ago you could just leave them to have a wash and then go back to them, now you have to stay with them the whole time and give them full assistance with everything". Another staff member said, "The needs of clients have worsened, that's just not taken in to account".

This is a breach of Regulation 18 (1) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Although the provider had reported safeguarding incidents as required, information about incidents that had occurred within the home was not always available. The registered manager told us this was because few safeguarding incidents had occurred within the home. There was a current on going safeguarding that had been reported in October 2017, we did not see that any action had been taken to review this concern, internally by the provider. The registered manager told us this was something they would action when the investigation had been concluded. We spoke with staff who were unable to confirm to us what safeguarding's had occurred within the home since the last inspection and were not aware that any action or changes had been implemented following these. This meant we could not be assured when safeguarding incidents had occurred the provider had systems in place so that improvements could be made and lessons learnt.

Staff knew how to recognise and report potential abuse to keep people safe from harm. One staff member told us, "Its making sure everyone is safe and that we are delivering safe practices". Another staff member said, "Make sure people are safe in their surroundings and free from any kind of abuse". They went onto say, "I would report my concerns to the home manager or a nurse, I think they would report it appropriately". We saw there were safeguarding procedures in place. We saw that when needed, concerns had been raised appropriately by the provider and safeguarding referrals had been made. This was in line with the provider's

procedures.

Staff told us and we saw protective equipment including aprons and gloves were used within the home. One staff member said, "No we never run out there is always enough, it's ordered each week". This demonstrated that protective equipment was used in the home in line with infection control procedures. We also saw the provider had been rated as five stars by the food standards agency and the cook confirmed to us they had received the relevant training needed to work within the kitchen environment. The food standards agency is responsible for protecting public health in relation to food.

People received their medicines as required. One person said, "They are pretty good with my medicines, they bring them to me regularly". Another person told us, "I'm happy with how staff deal with medicines, if I need painkillers I get them straight away". We saw staff administering medicines to people in a kind and caring way. The staff spent time with people explaining what the medicine was for and ensuring they had taken it. When people had medicines that were on an 'as required' basis we saw this was offered to them first. We saw there was guidance known as PRN protocols available for staff to ensure people had these medicines when needed. A pharmacy had completed a recent audit on medicines within the home and the provider was working through the recommendations they had made. There were effective systems in place to store medicines to ensure people were safe from the risks associated to them.

We looked at six recruitment files and saw pre-employment checks were completed before staff could start working in the home. We saw there were systems in place to ensure nurses had the correct registration and this was up to date. This demonstrated the provider completed checks to ensure the staff were suitable to work with people in their homes.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so or 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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. 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).

We checked to see if the provider was working within the principles of MCA. For some people mental capacity assessments had been completed when needed. However, it was unclear how decisions regarding their capacity had been made. All the assessments we looked at were the same. For example, the area being assessed was recorded as, 'unable to make decisions that affect life and wellbeing'. No capacity assessments we looked at had a date and there was no outcome to the decision if the person lacked capacity or not. There were no capacity assessments in place for any other areas. For example, when people were using bed rails, sensor alarms or when medicines were administered for them. Staff gave us mixed views about who in the home had or lacked capacity. One staff member told us only one person living in the home lacked capacity, whereas another member of staff said around ten people lacked capacity. When people lacked capacity we did not see how decisions had been made in people's best interests and we saw consent forms had been signed by relatives on behalf of people. Relatives are unable to sign consent forms on behalf of other people. This meant because all the assessments were the same we could not be sure people's capacity had been fully considered.

When people were being restricted unlawfully this had not been considered. The registered manager told us that no authorisations were in place and no applications to the local authority had been made. However we saw that some people were being restricted and this had not been considered, for example people were using bed rails, door sensors and other alarms. Furthermore for one person we saw documented, they had 'been found by the front door and brought back in'. It was documented the person had been 'quite agitated by this'. Staff and the registered manager did not demonstrate an understanding of mental capacity or DoLS. One staff member said, "I'm not sure, I don't think I have had training on that". When we discussed our concerns with the registered manager they told us, "I don't think we are restricting people". This demonstrated that they did not understand the range of restrictions in use and meant the principles of MCA were not followed.

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

Referrals to health professionals were not always made in a timely manner. For example, we saw one person was at risk of falls and had continued to fall for a period of six months. There was no evidence a referral to the falls team had been made and a member of staff confirmed this to us. We also found another person was at risk of choking, a referral had been made to SALT in July 2017. The person continued to be at risk and

incidents continued to occur. There was no evidence if this person had been seen by SALT or if the referral had been followed up by the provider and the person remained at risk.

Concerns were raised about the use of agency staff within the home. One person said, "Some are useless, they can't use slide sheet or turn you in bed". We spoke with staff about the agency staff within the home. One staff member said, "Some are very good but then we get others who can't use the equipment or anything". They went on to say, "I don't think they have an induction when they start here, we just show them what needs to be done". The registered manager told us agency staff completed an induction and were all suitably trained. We asked to see the agency inductions and the last one had been completed in 2015. This meant we could not be sure all staff were suitably inducted or trained.

Permanent staff received training that helped them support people. One person said, "Regular staff are very good and trained to use equipment". Staff told us they received training and their competencies were checked in some of the areas. One staff member said, "I have had training and it's good. The most recent I completed was end of life care, we had to complete a booklet for that". Another staff member said, "I have had moving and handling training, they do checks to make sure I am doing it right". The registered manager told us how staff received themed supervisions to ensure staff competencies were continually checked. The registered manager told us how they had implemented the care certificate. The Care Certificate has been introduced nationally to help new care workers develop and demonstrate key skills, knowledge, values and behaviours which should enable them to provide people with safe, effective, compassionate and high quality care. The registered manager said that all new starters would complete the care certificate as part of their induction. This demonstrated staff were supported to receive training relevant to meeting people's needs.

The registered manager told us and we saw some bedrooms within the home had been recently refurbished. They told us there were plans in place to renovate other areas including communal areas. However the home was not designed to support people living with dementia, we did not see any signage or adaptations that would offer appropriate support for people. For example, all bedroom doors were the same; there were no pictures or personal objects that people may identify as being theirs.

People had the opportunity to attend health appointment. One person said, "The doctor comes if I need them". A relative told us, "My relation has had an eye test and the chiropodist visits fairly regularly". Records confirmed people saw the doctor, chiropodist and dentist when needed.

People enjoyed the food available and were offered a choice. One person said, "They have improved on the food, there is a choice of meals, the food is okay". Another person told us, "Meals very good indeed, I have what I want, given choices day before". We saw there were cold drinks available in the communal areas for people. And hot drinks and snacks were offered in the communal areas throughout the day.

We saw when needed, information was available in care files relating to current legislation. For example; one person had a pressure sore. There was printed guidance of the most up to date information from relevant bodies including the wound care and pressure ulcers guidance from the Dudley group NHS. This meant staff had this information available to consider when offering support to people.

Good

Is the service caring?

Our findings

People and relatives were happy with the staff. One person said, "The great majority of staff are caring, helpful and nothing they wouldn't do for you". Another person said, "They are wonderful". A relative told us, "They all seem friendly, if you ask them for something they will help". We observed people were supported in a kind and caring way in a relaxed and friendly manner. For example, when someone was transferred using specialist equipment, staff offered the person reassurance throughout.

People's independence was promoted. One person said, "I can go out whenever I want but I'm not very bothered". Another person said, "I am able to do what I want more or less, the staff offer me assistance if I ask". Staff gave examples of how they encouraged people to be independent. One staff member said, "So I may give someone the flannel and let them wash their face themselves if they can. I let them do the bits they can still do for themselves independently". The care plans we looked at showed information about the levels of support people needed for example with mobility. This demonstrated people were supported to maintain their independence.

People made choices about their day. One person said, "I like to stay in my room". Another person said, "I stay in my room they pop in and see how I am doing but it's my choice and I am happy in here". Staff told us they offered people choices about what clothes they would like to wear, where they would like to sit and if they would like to take part in activities or not.

People told us and we saw that their privacy and dignity was promoted. One person said, "They always knock and treat me with dignity and respect when bathing". Another person told us, "They always knock the door and treat me with respect. They are very, very good and don't rush me". Staff gave examples how they used this to support people. One member of staff explained how they would always knock on the doors of people's bedrooms before entering. We observed staff did this. This demonstrated that people's privacy and dignity was upheld.

Relatives and visitors we spoke with told us the staff were welcoming and they could visit anytime. A relative said, "Staff are friendly, approachable, if they can help you they will put themselves out, always get an answer". We saw relatives and friends visited throughout the day and they were welcomed by staff.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive personalised care that was responsive to their needs. One person told us, "Sometimes I feel they don't understand my medical condition". Another person said, "I miss my showers, I only get one once a week. They say if I had one everyday everyone else would want one. I really hate it I have a flannel wash every day. Tomorrow is Wednesday which is shower day, the highlight of my week". The care plans we looked at did not always reflect people's individual needs. For example one person living at Prestwood Coach House had pressure damage. There was a standardised care plan in place for this. The care plan was written clinically and sentences or paragraphs that did not apply to this person were crossed out. However, the tissue viability nurse had visited the person and made individual recommendations. For example, to use specialist equipment, two hourly repositioning and for the person's temperature to be monitored daily. There was no review of the care plan after this and the information recorded did not reflect this individualised advice. Staff we spoke with were not aware of the advice and we could not be sure this was followed. For example, if the person's temperature was not being monitored as required.

We looked at records for another person. We saw that in the previous seven months the person had lost weight and continued to do so. We could not see what action the provider had taken. There was no care plan in place that reflected these concerns and documentation about what action they were taking. For example, weather the person was receiving a high calorie diet or more snacks were encouraged. The person continued to be weighed monthly and they had not considered weighing the person more often even though their weight had continued to reduce. The provider had not made a referral to the dietician and staff confirmed that no action had been taken.

People's cultural needs were not fully considered. Initially we were told by the registered manager no one living at the home needed support with their cultural needs; however on review we observed there were people. One person was born in another European country. They spoke two different languages. There was no information documented in the person's assessment that related to this. We saw there was a care plan in place for communication which stated the person 'sometimes finds it difficult to communicate' this went on to say due to the two languages they spoke. There was no other information on how this person was supported with this. Staff told us they had learnt some of the language from the person and in their own time however the provider had not offered them support with this. Furthermore it was documented in the communication review that this person was becoming increasingly confused and agitated and reverting back to their other language. No further action had been taken or considered for this person.

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

The home was supporting people who were living with dementia; but they had not fully considered any dementia support. For example, at mealtimes people were asked the day before what they would like to eat at mealtimes. There were no pictures or prompts used to support people to make their choices and there was no reminder of what they had ordered when the meal arrived. Therefore we could not be sure people understood the choices they had made. We asked staff if photographs of pictures were used to support

people to make choices. One staff member said, "No that would be really simple to do".

People did not always know how to complain. One person said, "If any concerns I would speak to people causing the concerns, I am not aware of complaints procedure". Another person said, "I would speak to my daughters or wife if I had any concerns". We saw the provider had a complaints procedure and when formal complaints had been made, they had been responded to these in line with this. We saw a person living at the home had made a complaint. They told us they were happy with the outcome of this. We did not see any other complaints had been made.

Staff knew people well. One person told us, "I'm happy here with staff that make me feel safe and well cared for". One staff member said, "We are a really good team, we put the people first. We like to do things right, spend time with people and deliver good care to them". Staff told us they would find out information about people from their care plans and risk assessments as well as other staff. If people's needs changed they told us this would be shared with them in handover.

People had the opportunity to participate in activities they enjoyed. One person said, "Its art and craft today, I love that, usually something going on each day". We saw displayed around the home up and coming events. This included external entertainers and church services. We saw that people had the daily newspapers delivered and were supported to read these by the activities co-ordinator. People had the opportunity to participate in activities and we saw people were supported to make Christmas cards. We spoke with one of the activity coordinators who told us, "I asked people what they want to do and then do a monthly review. We do one to one sessions with people including having a chat, reading the bible, doing word searches and manicures".

Although there was currently no one receiving end of life care the provider had considered this for people. There were advanced decisions in place for people in relation to their final wishes and some people had anticipatory medicines in place should they need them. The provider also had palliative care champions in place. A palliative care champion is a staff member who is trained in this area and focuses on end of life care for people.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we found there was a lack of confidence that concerns raised would be dealt with and people did not always know who the registered manager was. Quality checks were in place but did not always bring about change. At this inspection we found the necessary improvements had not been made.

There was a registered manager in place, five of the seven people we spoke with did not know who the registered manager was. One person said, "I'm not sure who the manager is". The registered manager told us that since the last inspection they had listened to the feedback and were now more available within the home. They said, "I'm around the home most days", They went on to say, "As directors we are all more involved and available". The six staff we spoke with told us the registered manager was not always available within the home. One staff member said, "They never come over here they are based in the office in the other home, even if we have a meeting we have to go over there to them". Another staff member said, "Once in a blue moon they come over". A relative commented that today was the first day they had seen the registered manager in the home. The registered manager told us the home manager was responsible for the day to day running of the home. However this staff member worked as a nurse and did not always have the time needed. For example on the day of our inspection they were the only nurse on the afternoon shift, and responsible for delivering care and medicines. They completed a weekly care management report and for several months it had been documented that due to the home being busy, they had been unable to find time to complete management tasks, such as evaluating care plans. We reviewed the information in the PIR where it said, 'Weekly management reports completed by home manager and distributed to directors'. Therefore we did not see how this information had been actioned by the directors when concerns had bee raised.

Staff did not always feel concerns they raised were actioned by the provider. One staff member said, "We raised our concerns, they say all the right things, you think they have listened but nothing ever changes". Another staff member told us, "Staff are not happy, even more so than before, nothing changes, we have raised our concerns time after time especially about staffing levels and nothing changes". We reviewed the PIR the provider had completed, this stated 'At our last inspection we were extremely disappointed by the findings that we required improvement in this area, as a result of this we reviewed our structure and our performance'. As the provider remains requires improvement in this area we did see how this had been implemented by the providers.

We saw that audits were completed by the provider however they were not always effective in identifying areas for improvement. For example, we saw that audits were completed on falls within the home. This was a tally of how many falls had occurred. We did not see how this information was then used to drive improvement within the home. Furthermore it had not identified our concerns around the person who was continually falling and at risk. We did not see how the provider used information within the home to learn and improve. For example when incidents or accidents occurred there was no evidence investigations were taking place and changes made in light of these.

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

2014.

We could not be sure the provider notified us of all significant events that occurred within the home. For example, we saw that one person had been scalded; we did not receive a notification as required in relation to this. We had however, received notifications in relation to pressure wounds and some injuries.

People and relatives had the opportunity to complete surveys relating to the service. We saw that when people had made suggestions about activities they would like to participate in these had been introduced. There was a you said, we did displayed on the activity board. Information included, 'we would take part in a sing a long' so we 'printed off sheets for everyone to follow'. There was also 'The Prestwood friends and family test'. This was a short survey completed by friends and relative. Comments included, 'Very friendly' and 'Work well under busy conditions'. The provider produced a newspaper for both relatives and staff to communicate events and findings that were taking place within the service.

We saw the service worked in partnership with other agencies, for example we saw a student nurse was on placement within the home. The provider previously told us and information was recorded in the PIR about joint working with the local university to address the concerns with shortage of nurses. The provider was displaying their previous rating on their website and in the home in line with our requirements.

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 People did not always receive care in their preferred way. Care plans were not always reviewed to reflect people's needs and when people had cultural needs these had not always been fully considered.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent It was unclear when people lacked capacity to make decisions for themselves and when needed decisions had not always been made in people's best interest. People were unlawfully being restricted and this had not been considered

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not always reviewed or managed in a safe way

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Staff did not feel listened to and when needed that action was taken. People and relatives did not always know who the registered manager was. Quality checks did not always drive

improvement within the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not always enough staff available for people and they had to wait for support.