

# Forthmeadow Limited

# Eastwood House

## Inspection report

Eastwood House  
Eastwood  
Nottingham  
NG16 3HS  
Tel: 01773 712003

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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



### Overall summary

We carried out an unannounced inspection of the service on 14 December 2015.

Eastwood House provides accommodation and personal care for up to 19 older people including people living with dementia. At the time of our inspection there were 17 people living at the service.

Eastwood House is required to have 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. At the time of the inspection a registered manager was in post.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and to report on what we find. This is legislation that protects people who are unable to make specific decisions about their care and treatment. It ensures best interest decisions are made correctly and a person's liberty and freedom is not unlawfully restricted. People's rights were not fully protected.

# Summary of findings

People told us that they felt staff provided a safe service. Staff were aware of the safeguarding procedures and had received appropriate training. However, safeguarding incidents and concerns had not always been reported to the local authority who have the responsibility of investigating safeguarding's or CQC.

People received their medicines as prescribed and were managed correctly. Safe recruitment practices meant as far as possible only people suitable to work for the service were employed. Staff received an induction, training and appropriate support.

Accidents and incidents were recorded and appropriate action was taken to reduce further risks. However, there was no analysis or review of this information to help identify any themes, patterns or concerns. Risks plans were in place for people's needs and were regularly monitored and reviewed. Some concerns were identified in relation to the internal and external environment.

People told us that there were sufficient staff to meet their needs. People's dependency needs had been reviewed and plans were in place to increase the morning staffing levels.

People received sufficient to eat and drink and were positive about the choice, quality and quantity of food and drinks available. People were supported to access healthcare services to maintain their health. People's healthcare needs had been assessed and were regularly monitored.

People we spoke with who used the service and visiting relatives were positive about the care and approach of staff. People's preferences, routines and what was

important to them had been assessed and recorded. People we spoke with raised some concerns about the opportunities they received to pursue their interests and hobbies.

The provider enabled people to be actively involved in the development and review of their care and support if they wished. This also included meetings to discuss and share feedback about how the service was provided and additionally were asked to complete feedback questionnaires.

People told us they knew how to make a complaint and information was available for people with this information. The provider did not have a clear process of recording complaints. Confidentiality was maintained and there were no restrictions on visitors.

The provider had checks in place that monitored the quality and safety of the service. However, the provider did not have a system or plan in place that gave them oversight of the action required to continually improve the service.

We identified a breach of Regulation 11 of the Health and Social Care Act 2008 Regulations 2014: Need for Consent. The provider had failed to act in accordance with the provisions of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. We identified concerns where the provider had placed restrictions upon a person's care and support without the correct authority to make these decisions. You can see what action we told the provider to take at the back of the full version of the report.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not consistently safe

Staff had received appropriate safeguarding adult training. The provider had not always responded appropriately to safeguarding concerns.

We found some risks to the environment. People were protected from risks associated to infection control. Cleanliness and hygiene measures were in place. Medicines were managed safely.

The provider operated safe recruitment practices to ensure suitable people were employed to work at the service. There were sufficient staff available to meet people's needs safely.

Requires improvement



### Is the service effective?

The service was not consistently effective

The provider was not fully adhering to the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People were supported to access external healthcare professionals when needed. The provider ensured people maintained a healthy and nutritious diet.

Staff received the training and support they needed to meet people's needs.

Requires improvement



### Is the service caring?

The service was caring

People were supported by staff that were caring and supportive. Staff were knowledgeable about people's individual needs.

People were given opportunities to express their opinion and felt respected and supported to do so. Independent advocacy support was available for people.

There were no restrictions on friends and relatives visiting their family.

Good



### Is the service responsive?

The service was not consistently responsive

People's needs had been assessed; care plans lacked detail in places. People received opportunities to participate in activities but it was not clear if these were based on people's individual hobbies and interests.

People were supported to contribute to their assessment and involved in reviews if they wished about the service they received.

Requires improvement



# Summary of findings

People knew how to make a complaint and had information available to them. Complaints had not always been recorded.

## Is the service well-led?

The service was not consistently well- led

Staff understood the values and aims of the service. The provider was aware of their regulatory responsibilities but had not always informed CQC of events or incidents as required.

The provider had systems and processes that monitored the quality and safety of the service. However, there was no clear plan or oversight of how the service would continue to be developed or improved.

People that used the service and or their representatives were supported to give their feedback about the service. Staff felt supported.

**Requires improvement**



# Eastwood 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 14 December 2015 and was unannounced.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information the provider had sent us including statutory notifications. These are made for serious incidents which the provider must inform us about. We also contacted the local authority, the GP, Healthwatch, a dementia community nurse for their feedback.

The inspection team consisted of 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.

During the inspection we spoke with four people that used the service and five visiting family members or friends for their experience of the service. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also saw the way staff interacted with the people who used the service throughout the day. We spoke with the registered manager, the cook, the housekeeper, a senior care worker, two care staff and two visiting healthcare professionals a district nurse and a rehabilitation support worker. We looked at all or parts of the care records of four people along with other records relevant to the running of the service. This included policies and procedures, records of staff training and records of associated quality assurance processes.

After the inspection we spoke with the provider.

# Is the service safe?

## Our findings

The provider had procedures in place to inform staff of how to protect people from abuse and avoidable harm. Whilst staff had received adult safeguarding training people were not fully protected due to safeguarding procedures not being followed. People we spoke with did not raise any concerns about their safety in relation to abuse. One person told us, “Oh yes, I feel safe now.” Another person told said, “I’m okay, they’re nice people, the staff.”

Staff spoken with confirmed that they had received safeguarding adults training and told us what their role and responsibilities were in protecting people. Staff had a good understanding of what constituted abuse and what to look for to indicate it was happening. They understood the process for reporting concerns. We asked the registered manager what systems and procedures were in place for managing people’s money. We saw from records viewed that expenditure was recorded and receipts kept, these were checked by the manager on a monthly basis. From the sample we looked at we saw that cash balanced with the corresponding recording. These arrangements helped to see how people were supported to manage their money.

There had been some incidents of a safeguarding nature that had been responded to appropriately by the provider during 2015 and at the time of this inspection there was an ongoing police investigation. However, we were concerned that an additional safeguarding incident had not been shared with the local authority safeguarding team or CQC. The provider told us what action they had taken and provided us with records that confirmed appropriate action had been taken.

Some people had needs associated with their mobility and required assistance from staff to use the lift or stairs to reduce any risks. One person told us, “I always use the lift and have to wait for someone to help me. I have to wait a long time if they’re [staff] are busy.”

A relative raised concerns with us that their family sometimes used the stairs without support of staff and in a manner that put themselves at risk of injury. The person’s care records stated the person required assistance from staff to use the stairs. We discussed what had been shared with us with the registered manager and a senior care worker. The registered manager was unaware of any incidents of this person using the stairs independently.

However, the senior care worker was aware of this and confirmed other staff had reported incidents to her, but there was no written record of these concerns or any action taken. The registered manager said they would discuss these concerns with the staff team. This told us that people were not always protected appropriately from avoidable harm.

From the sample of care records we looked at we found individual risk assessments had been completed for people. For example, risks associated with developing pressure ulcers, nutrition, general health, and falls. Information was available for staff of the actions required to reduce risks. We found that some care records were more detailed than others. The registered manager told us that they were in the process of introducing a new electronic care record system that would be an improvement on the current documentation used.

We spoke with a visiting district nurse and a rehabilitation support worker from the community ‘Falls Team’. Both said that the registered manager made appropriate and timely referrals if concerns or risks were identified with falls or skin damage. Both told us that they felt the staff team worked well in managing and reducing any risks.

Personal evacuation plans were in place in people’s care records; this information was brief and did not fully describe the assistance people would need in the case of an emergency evacuation of the building. For example, whilst plans included the support required, there was no consideration to the person’s health care needs such as issues relating to memory loss or anxiety, and how this may affect the person in an emergency.

The registered manager kept a log of falls for the community Falls Team and accidents and incidents were recorded. We saw examples where appropriate action had been taken when concerns had been identified. However, the registered manager had no system in place that gave them oversight of themes, trends and patterns which may have identified preventative measures. People had access to an enclosed patio area. The registered manager told us that people did not access the garden independently due to safety. We identified some concerns regarding the entry and exit to the home and discussed this with the registered manager. They agreed to review the current system.

There were sufficient staff deployed appropriately to meet people’s individual needs and keep them safe. People that

## Is the service safe?

we spoke with did not raise any concerns about the availability of staff. People told us that staff responded to requests of assistance in a timely manner. One person told us, “They [staff] come quite quickly.” Another person said, “I haven’t had to use it (call bell) yet, but see them [staff] going to people.”

Staff spoken with told us that they found the mornings were particularly busy times and that this affected how much time they spent with people. One staff said, “We need more staff in a morning, we’re very busy which can mean people are left alone in the lounge.” Another staff told us, “I think the staffing levels are increasing, we need more staff in a morning.” The registered manager told us that they monitored people’s dependency needs which informed them of the staffing levels required. They confirmed that an additional member of staff and recently been recruited to increase the morning staffing levels.

Our observations found that, particularly in the morning, people who used the service spent lengthy periods in communal areas with limited staff support. Staff availability was noticeably better in the afternoon as staff were less busy and had more time to spend with people.

Staff employed at the service had relevant pre-employment checks before they commenced work to check on their suitability to work with people.

People received their medicines safely and as prescribed by their GP. People we spoke with, including visiting relatives, said they had no concerns about how medicines were managed. One person told us, “They [staff] ask me if I need any paracetamol if I’ve got any of my head pain.” A relative said, “We don’t know what his meds are for but we’re happy with the way they [staff] do it.”

We looked at the medicines and records of a number of people living at the home and observed a senior care worker administering people their medicines. Our observations showed that medicines were being administered appropriately to people in accordance with their needs. Medicines were being stored securely. The recording of room temperature occasionally exceeded the recommended temperature but fans were in place as a measure to manage this. People had a medicine care plan which set out people’s medicine regime and how they liked to take their medicines. We saw staff administering medicines had completed regular training and competency assessments. There was evidence of a recent medicines audit by the pharmacy that supplied the medicines and regular checks were in place and completed by the management team. A medicines policy was in place that was based on best practice guidance.

People were protected by the prevention and control of infection. People we spoke with told us that they felt that the cleanliness of the home and laundry was good. One person told us, “They [staff] change my bed often and the place is clean.” A relative said, “His bedroom is fine and the laundry is good.”

We spoke with the housekeeper who told us what systems and procedures were in place to ensure people were protected from associated infection control risks. We looked at the cleaning schedules. These were up to date and confirmed correct measures were in place to maintain cleanliness and hygiene. Our observations of the home and equipment found no concerns.

# 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 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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Whilst we saw some records that showed MCA assessments and best interest decisions had been made and recorded, these had not always been made correctly in accordance to this legislation. For example, some people had power of attorney that gave another person the authority to make decisions on their behalf for either care and welfare and, or financial decisions. Some decisions had been made without the correct authorisation in place. We were aware of a person who was given their medicines covertly. This is the term used when medicines are administered in a disguised way. For example in food or in a drink, without the knowledge or consent of the person receiving them. The registered manager had correctly involved a healthcare professional in this decision but had not fully followed the recommended guidance and was in the process of taking the required action.

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 whether the service was working within the principles of the MCA. There were no DoLS authorisations in place. The registered manager told us that they had spoken with the local authority DoLS team for some guidance and they had identified that some people required an application to be made. However, these applications had not been submitted. We identified an additional person that may have had their liberty restricted unlawfully, and requested the registered manager contacted the local authorities DoLS team which they did during our inspection. This told us that we could not be fully assured that people's human rights were fully protected.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 Regulations 2014: Need for Consent.

Staff told us how they involved people in consent for day to day decisions and showed some awareness of both the MCA and DoLS. One staff said, "We give people choices with day to day things such as their medicines, what to eat, where to sit, clothes to wear." An example was given where a person showed they wanted to leave the building, but had some mobility needs that posed a risk if they went out independently. Correct action had been taken by involving the GP to assess this person's needs. Records confirmed that staff had received relevant training on MCA and DoLS and the provider had a policy and procedure that was available to staff.

We observed that staff offered people choices and gave explanation before care and support was provided. Staff respected people's decisions and choices. We saw examples of do not attempt resuscitation order (DNACPR) in place. From the sample we saw these had been completed appropriately.

Some people were living with dementia and experienced high levels of anxiety at times that affected their mood and behaviour. We saw staff had been provided with some guidance of how to support people at these times. Additionally, in one person's care file we saw staff had been provided with information from the Alzheimer's Society 'dealing with aggressive behaviour'. We contacted a dementia community psychiatric nurse who visited the home for their feedback; they did not raise any issues or concerns about how people's needs were being met.

People were supported by staff that had received relevant training and support to do their jobs and meet people's needs. People we spoke with, including relatives, told us that they found staff to be knowledgeable and competent. A relative told us, "The staff seem competent. We've seen the changes since [family member] moved in and it's been getting better."

Staff told us they had received an induction and said that the quality of the training and support was good. One staff told us, "The quality of the training is good, we have external trainers, I've completed the care certificate." Another staff said, "We have meetings with the manager every three to four months. We talk about concerns, ideas and receive feedback on our performance."

Training records showed that staff undertook a wide range of training that was appropriate for the needs of the people at Eastwood House. This included first aid, fire safety,

## Is the service effective?

infection control and moving and handling. The provider had an induction programme for new staff that included the Skills for Care Certificate. This is a recognised workforce development body for adult social care in England. The certificate is a set of standards that health and social care workers are expected to adhere to. This meant that staff received a detailed induction programme that promoted good practice and was supportive.

We observed that staff were organised and communicated effectively with each other. The senior care worker led the staff team and delegated areas of responsibility. Communication systems were in place such as staff hand over meetings, a communication book and a diary was used to exchange information about people's needs. Staff were observed to follow safe practice when supporting people with their mobility needs. This included providing explanation and reassurance to the person they were supporting.

People were supported to eat and drink and maintain a balanced diet based on their needs and preferences. On the whole people told us that they were satisfied with the meal choices. One person said, "I'm always contented with it." A relative said, "I'd eat it! [family member] has put on weight since they've been here. They get a choice and they [staff] know his likes." and, "I don't know if [family member] know what a dish looks like though when he's choosing from a list." The cook advised that people were asked the day before what their choice of meal was. They confirmed that pictorial menus were not used to support people with communication needs. Some people were living with dementia it was not clear what means were used to ensure everyone was supported to express their choices.

Some people chose to eat their meal in their room; some people were cared for in bed due to their health needs and others used the dining room. We observed the food to look appetising, homemade and a generous portion.

Staff we spoke with showed a good understanding of people's nutritional needs and preferences. Specific dietary and nutritional needs in relation to people's healthcare needs or cultural or religious needs were assessed and included in people's plans of care. These needs were known by staff including the cook. Where concerns had been identified about people's weight this was monitored and referrals had been made to healthcare professionals for further assessment and support. We found food stocks were appropriate for people's individual needs.

People were supported to maintain good health and have access to healthcare services. People told us and visiting relatives agreed that people were supported with their healthcare needs. A relative said, "The optician came and gave [family member] some new glasses a little while ago. The doctor comes the same day and they're [staff] good, they keep us notified."

Staff told us that people's healthcare needs were known by staff and monitored for changes.

We received positive feedback from healthcare professionals about how people's healthcare needs were met by staff.

From the sample of care records we looked at we found people's healthcare needs had been assessed and planned for and were monitored for changes. There was evidence of access to a wide range of healthcare professionals including a speech and language therapist, the dementia outreach team, GP and chiropodist. This told us that people could be assured that their health care needs were known and understood by staff.

We observed that people had appropriate equipment available to meet their needs, this included, specialist bathing equipment and hoists. We found the upstairs lacked signage to support people living with dementia to orientate themselves such as pictures or names on bedroom doors.

# Is the service caring?

## Our findings

People we spoke with including visiting relatives spoke positively about the care and approach of staff. One person told us, "I've no complaints at all on the staff." A visiting relative said, "I think they're [staff] good. They let [family member] do what they can do then help with what they need."

Feedback from healthcare professionals was positive about the care and support provided by staff towards people that lived at Eastwood House. One healthcare professional told us, "Staff are pleasant and caring; they have developed good relationships with people they care for."

Staff spoken with demonstrated they were kind, caring and compassionate. One staff member said, "I used to work for an agency that worked here and it's the best place I've worked in, which is why I stayed on. I just love being a care worker." Another told us, "I moved to work here from another care home. I find the staff very thoughtful towards people; it's a happy place to work where residents are involved with things." A visiting friend of a person told us, "The staff give [name] positive attention and are available when they are needed." and, "I'd book myself in here if my legs gave up."

We found staff to be knowledgeable about the needs, preferences and routines of people. Whilst our observations showed that staff had limited time to spend with people due to the level of work they had to do, we saw positive staff engagement with people. For example, in the morning we observed a person that looked anxious whilst in the lounge. Staff were busy and people were frequently left without staff being present. When staff did enter the lounge they failed to notice the person's anxiety. We were concerned about this person's increased anxiety and informed a member of staff. They responded quickly and showed a nice, caring and reassuring approach which the person responded well to, they soon relaxed and became more content. We noted another staff member whilst assisting a person to walk, gave reassurance when the person began to show signs of anxiety by saying, "Don't worry, we're here to look after you."

We also observed staff to show dignity and respect when supporting people. Some people were cared for in bed due to their healthcare needs. We observed a member of staff knock on a person's door before entering and greeted them

using the person's preferred name. We heard the staff ask how they were feeling and suggested they sang a Christmas song together. The person responded positively to this and the two of them sang together enjoying each other's company.

We noted that the cook had a lot of direct contact with people when serving breakfast and lunch. Through our observations of their approach and communication with people, they were very popular with both people who used the service and visiting relatives. They were a personable, caring team member that knew people well and had developed positive relationships with.

People that we spoke with and visiting relatives told us they were not aware of the content of care plans but said that they were informed of any health related concerns. People said that they were encouraged to be as independent as they were able. One person said, "They [staff] let me get up and do my own thing, as I can."

Staff told us that they promoted independence and choice making as much as possible. One staff said, "We get to know what people can do and encourage people to be as independent at much as possible."

We observed lunchtime being served in the dining room. Whilst we noted the atmosphere was relaxed and calm we identified some areas where the approach of staff could have been better. For example, a staff member put the television on without giving people the option of if they wanted it on or the choice of an alternative such as music. We noted a person ate independently but very slowly. Staff were not seen to offer any assistance and their hot pudding was placed in front of them before they had finished their first course. This meant that the pudding would likely be cold before they ate it. Another person was given a bowl of the hot pudding then another staff came in, took it away and said to another staff, "She'd be better with a yoghurt. She usually has one." There was no interaction with the person, or giving them a choice and staff talked over the person.

Information about independent advocacy support was available. This meant should people have required additional support or advice, the provider had made this information available to them.

People told us how staff respected their privacy and dignity and gave examples such as staff knocking on their doors before entering.

## Is the service caring?

Staff we spoke with told us how they provided people with privacy, dignity and respect. One staff said, “We always knock on people’s doors before entering, are polite and respectful about how we address people.” Another staff told us how they ensured people’s dignity was respected when delivery personal care.

The importance of confidentiality was understood and respected by staff and confidential information was stored safely. One staff said, “We are aware of the importance of maintaining confidentiality.”

# Is the service responsive?

## Our findings

People told us that they were involved in the initial assessment prior to moving into Eastwood House. From the sample of care records we looked at we saw that people and or their relatives had contributed to the initial assessment. This information was then used to develop individual care plans that advised staff of what people's needs were and how to meet these needs.

Staff we spoke with told us that they had the required information available to them to enable them to meet people's needs. They demonstrated that they were aware of people's preferences and routines. One staff said, "The care plans are much better than they use to be." Another staff told us, "We have the information we need, but it's about getting to know people, we also rely on families sharing information."

From the sample of care records we looked at we found care plans were reviewed on a regular basis. We also saw that people who used the service and their relative if appropriate, were invited to attend a meeting to discuss their care and support needs. This told us that people received opportunities to participate in discussions and decisions about the care and support they received. We also saw that staff had available information about people's life story that included past events, family history, hobbies and interests and religious and spiritual beliefs. People's routines were recorded such as their bedtime and morning preferences, food likes and dislikes and end of life preferences. This told us that staff had the information available to enable them to provide care and support that was based on people's individual needs and wishes.

People that we spoke with including visiting relatives all said that opportunities to pursue interests, hobbies and social activities and stimulation were limited. One person told us, "I don't know about any activity things. I like to read or watch television. I'd like to be taken for a walk though as I used to live round here." Another person said, "I watch television, nothing really happens. But we have a laugh." We received similar comments from relatives about the lack of activities. One relative said, "There's not a lot. Sometimes they play a game and they have a singer in sometimes. I think there's a monthly church visit too." and,

"They had a musical DVD on once in here (lounge) and it was lovely, I'd not seen them do that before. We said why don't they do that simple sort of thing more often and turn the damned television programmes off."

On the day of our inspection staff told us that the part-time activity organiser would be coming in early afternoon and that a church group was also visiting. However the activity organiser was unavailable and the church group did not arrive. We did not see that an alternative activity was provided.

We observed a visiting health care professional provided an exercise group for six people. This activity was provided each week. People were actively engaged and looked as though they enjoyed the session with classic FM on the radio in the background. We also observed a person reading the daily paper and people sitting in front of the television. However, we did not observe staff offer people a choice of what channels to watch or if they wanted the television on. No activities were provided and there was no memorabilia or activities that provided stimulation or occupation for people.

We saw there was an activity plan on display that informed people of the activities available during the month of December 2015. Activities included the hairdresser visiting, bingo, Christmas card making, music and sherry, cinema DVD and singing. We also noted on display that people had been offered a choice of activities and some people had chosen activities such as going into the local community to the shops, café or pub.

The provider enabled people to share their experiences, concerns and complaints by displaying information of the procedure to follow. People that we spoke with told us that they had not needed to make a complaint but felt able to talk to staff if they had any concerns. A visiting relative told us, "We've [family] not complained before. But if we did, we could tell anybody."

Staff told us if a person wanted to make a complaint or raise a concern they would try to resolve the issue and report it to the manager.

We spoke with the registered manager about complaints received. They told us they had not received either formal or informal complaints and if they did, they would pass them onto the provider to investigate. We looked at the complaints log and saw three letters that the provider had

## Is the service responsive?

sent to relatives about incidents that occurred in 2015 advising of the action taken to concerns raised. The provider told us that they had received a complaint that they were investigating.

# Is the service well-led?

## Our findings

People that used the service and their relatives and representatives received opportunities to participate in the development of the service. People we spoke with could not recall if there were meetings arranged for them to share their views about the service. However, records confirmed that monthly 'resident' meetings were arranged. Meeting records for June, July, August and September 2015 showed that people were given the opportunity to share their views. When people had made suggestions or requests these had been acted upon. For example, some people had requested more outings into Eastwood village. The following meeting record gave people feedback about previous requests, and stated that the activity coordinator had since supported people on visits as requested. A 'trolley shop' for people to buy essentials and treats had been provided as a response to people's request.

Staff told us that they felt valued and listened to, and that the registered manager encouraged them to share their ideas about how the service could be developed. The registered manager told us staff meetings were held bi-monthly and we looked at records dated May, July and September 2016. These records demonstrated that staff were encouraged to be involved in discussions and decisions of how the service could be further developed.

Staff had a clear understanding of the vision and values of the service. One staff told us, "It's a very friendly, family orientated, warm, loving home for people." Another staff said, "The staff team get on well, I love it and have no concerns, we're resident focussed."

Staff knew about the whistle blowing policy and procedure. A whistle-blower is protected by law to raise any concerns about an incident within the work place. Staff said that they would not hesitate to use the policy if required to do so.

Healthcare professionals told us that they had developed a good working relationship with the registered manager and staff team. Staff were clear about their roles and responsibilities and accountability.

We received a mixed response from people about how visible the registered manager was within the home. Whilst some people spoke positively about having had regularly contact with the registered manager and could recall their name others were less aware. One person told us, "We've [family] sat in the conservatory (visitors room) and she'll

[registered manager] sometimes come in and have a chat when she sees us in there." A relative said, "If [name] needs something, the manager will tell us. She keeps us up to date."

Staff told us that they found the registered manager approachable and supportive and that they had an 'open door' policy for staff and people who used the service and their relatives or representatives.

Whilst we saw there were communications systems in place, these had not always worked as effectively as they should have in keeping the registered manager fully aware of any concerns or issues. Additionally, the registered manager had not fully protected people in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Registered persons are required to notify CQC of certain changes, events or incidents at the service. Records showed that since our last inspection the provider had not notified CQC of all incidents as required. We discussed this with the registered manager and the provider's responsible person.

The provider had systems in place to monitor the quality and safety of the service. This included checks and audits completed by the registered manager and senior care staff for example for the environment, medicines, care plans and training needs for staff.

The registered manager told us the provider also visited the service on a regular basis to complete checks and audits. Staff we spoke with confirmed this and said they felt the provider was approachable and supportive. We asked to see these audits and any action plans that had identified where improvements were required. These were not made available to us.

We spoke with the provider's responsible person who confirmed they visited the service regularly to conduct checks on quality and safety. They said that they sampled certain records and demonstrated these had been checked by signing them. The registered manager and responsible person told us that they were aware of areas that required improvement, and gave an example of the introduction of new electronic care records. The provider told us they met as a management group and discussed issues and actions required. However, the system and processes in place on quality and safety did not show that the provider had oversight of what the required action and plans were to continually improve the service.

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 11 HSCA (RA) Regulations 2014 Need for consent</p> <p><b>Regulation 11 of the Health and Social Care Act 2008 Regulations 2014: Need for Consent.</b></p> <p>Where people lacked the capacity to consent to their care and treatment the provider had failed to act in accordance with the provisions of the MCA 2005. Regulation 11 (3)</p>

This section is primarily information for the provider

## Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.