

The Yercombe (Gloucestershire) Trust

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Inspection report

Yercombe Lodge
Stinchcombe
Dursley
Gloucestershire
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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 7 April 2016 and was unannounced. The last inspection of the service had been carried out in July 2013 and at that time there were no concerns. Yercombe (Gloucestershire) Trust provides accommodation for up to 10 people. The service looks after people on a permanent or respite basis on a four to six ratio. At the time of our inspection there were five people living at the service and five who were having a short respite stay.

There was 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.

People were satisfied with the way they were looked after and enjoyed being at Yercombe. We received positive comments about their views and experiences of the service. People got on well with the staff, were accommodated in clean and tidy surroundings and their care and support needs were fully met. Despite the positive views of people using the service and health and social care professionals, improvements were required in a number of areas as the service was in breach of four regulations.

Improvements were required with the management of medicines to ensure that people were not placed at risk. For those people who have short respite stays in the service, the staff were not double-checking that the handwritten entries they recorded in respect of people's medicines were correct. Some handwritten entries did not provide sufficient instructions on what dose or how often the medicine should be administered. There was a lack of knowledge and understanding amongst the staff team regarding when and if an emergency medicine should be administered.

The registered manager did not demonstrate a clear understanding of the safeguarding reporting protocols and would benefit from additional training and greater awareness of the locally agreed reporting procedures. The registered manager was also unclear as to the difference between safeguarding and the Deprivation of Liberty Safeguards (DoLS).

The registered manager did not demonstrate a clear understanding of DoLS legislation and was uncertain whether an application for one person was being processed by the local authority. The registered manager had not notified the Care Quality Commission regarding one person who was subject to a DoLS authorisation. The registered manager had only completed a basic MCA and DoLS on line training programme and would benefit from more in-depth training.

The systems the registered manager and provider (the trustee's) had in place to assess and monitor the quality and safety of the service were inadequate. There was no programme of audits and, where feedback had been obtained from people using the service, no actions plans were devised to drive the improvements needed. Following events such as accidents, incidents or complaints, there was no analysis of what had

happened. This meant the opportunity to identify any triggers or themes and then make changes to prevent or reduce reoccurrences was missed.

Staff were aware of their responsibility to keep people safe and to safeguard them from coming to harm. They knew how to identify and report abuse. The recruitment procedures followed when taking on new staff ensured that only suitable were employed.

Any risks to people's welfare were identified and well managed. There was a programme of regular checks in place to ensure that the premises and any equipment was well maintained. However the fire risk assessment needs to be reviewed as this had been completed many years ago.

The numbers of staff on duty each shift were calculated and based upon the collective care and support needs of the people in residence at any given time. Because the service offers short stay respite placement, the staffing numbers vary dependent on who the staff were looking after.

All staff had a programme of mandatory training to complete. This ensured they had the necessary knowledge and skills to carry out their roles effectively. The service rarely takes on new staff but must ensure that induction training for new staff is in line with the new Care Certificate, implemented in April 2015. The staff team were well supported by each other, the senior care staff and the management team.

People were provided with sufficient food and drink and were complimentary about the meals they were served. Their choices and preferences were met and meals were home cooked. People were supported to see health and social care professionals as and when necessary.

Staff were knowledgeable about the people they looked after and it was evident they had built up positive relationships based on trust and respect for each other. People were supported to dress smartly and looked well cared for. It was evident that people were treated with respect and dignity.

People's care and support needs were fully assessed before being offered either a permanent or short stay placement at Yercombe. Their needs were continually assessed, monitored and evaluated and the way they were looked after was adjusted if their care needs changed. On the whole the information and care records were kept up to date and reflected the support people wanted and required.

People were listened to and were encouraged to have a say if they were unhappy or wanted things done differently.

The registered manager had been at the home for many years as had many of the staff team. The staff team worked well together and said the registered manager was open and approachable and actively enabled and encouraged open communication.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

The management of medicines was not fully safe. Handwritten records for those people having a short stay did not involve a check by another staff member to ensure they were correct. Staff were not always fully informed of when medicines needed to be administered or what they were for

Staff had received training in safeguarding so would recognise abuse and know what to do if they had any concerns. The registered manager was not clear about reporting protocols.

New staff were recruited following safe recruitment procedures. This ensured staff were suitable to work with vulnerable people.

Risks were appropriately assessed and staff were provided with clear guidance on the management of identified risks.

There were enough staff on duty to support people safely.

Requires Improvement ●

Is the service effective?

The service was not fully effective.

There was a lack of full understanding about the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. People's rights may not be fully protected and they may be unlawfully restricted when they cannot consent to care and treatment.

Staff were well supported to do their jobs and were provided with training and supervision to ensure they had the necessary skills and knowledge to meet people's needs.

People were provided with sufficient food and drink, taking into account their nutritional requirements and personal preferences. The staff sought advice and assistance from health and social care professionals so that people's health and wellbeing was promoted and protected.

Requires Improvement ●

Is the service caring?

Good ●

The service was caring.

The whole staff team were caring and kind and wanted the people they were looking after to experience good care.

People were treated with respect and dignity. They were assisted to have a good quality of life with meaningful relationships.

Is the service responsive?

Good ●

The service was responsive.

People received the support they needed and had been identified when their care plans were written. The way people were looked after was amended when their needs changed. People were involved in deciding what support they needed and how this was to be provided.

People were able to spend their time as they wished and to take part in any activities that were arranged. They were listened to and staff supported them if they had any concerns or were unhappy.

Is the service well-led?

Requires Improvement ●

The service was not always well led.

The provider did not have effective quality monitoring systems in place therefore, was unable to know whether the service was safe, effective or meeting the required legislation.

Procedures were in place for recording and managing complaints, safeguarding concerns, incidents and accidents but there was no analysis of events in order that any lessons learnt could be addressed.

There was a good management structure in place. Staff were provided with good leadership and were well supported.

Yercombe (Gloucestershire) Trust

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

This service was previously inspected in July 2013. At that time we found there were no breaches in regulations. This inspection took place on 7 April 2016 and was unannounced. Two adult social care inspectors carried out this inspection.

Prior to the inspection we looked at information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We also looked at the 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 planned to make. We used the PIR to assist in our planning of the inspection.

During our visit we met and spoke with six people living at the home. We spent time with the registered manager and spoke with five other staff members. We looked at six people's care records, together with other records relating to their care and the running of the service. This included three staff employment records, policies and procedures, audits and quality assurance reports.

Is the service safe?

Our findings

People said, "I feel safe and there is always someone around to help me", "The staff are very kind to me and always gentle", "I am the ears and the eyes in the lounge area and I have never seen anything that has worried me" and, "The staff have to help me get around now so I don't fall. I am reassured they are there to help me". One person expressed their concerns that there could be times in the evening when staff were supporting people in their own rooms and there was no staff presence in the lounge area. They said this would only be for short periods of time.

Improvements were needed with the management of medicines. Some people who use the service had short stay admissions. Their medicines were brought in with them when they came to stay. The staff were hand writing details regarding what medicines were to be given and when, on a medication administration record (MAR chart). Another member of staff had not checked the recordings were correct and countersigned them. This shortfall had the potential to increase the risk of medicine errors being made. One person who had recently returned from hospital had hand written entries on their MAR chart but there were no instructions on how often the medicines were to be given. Another person was prescribed medicine to be given as and when needed (called a PRN medicine). The senior care worker we spoke with had no understanding of what the medicine was for and said the person would "know when they needed to ask for it". The registered manager said that staff would not administer this medicine at all but paramedics would be called to deal with any emergency.

The service needs to maintain proper records when verbal instructions were received from the GP. This was in respect of warfarin administration, where the dosage was changed dependent on blood results. These instructions would again need to be countersigned by another staff member.

Only senior care staff who had received safe administration of medicine training were involved with medicines. However once they had completed their training, their competency was never re-checked. The registered manager did not have measures in place to ensure that medicines were administered correctly.

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

All other aspects of medicines management were handled safely. People received their medicines as prescribed by their GP. Medicines were stored securely in lockable trolleys and controlled drugs were stored appropriately in the controlled drug cabinet. Any medicines no longer required were recorded and returned to the pharmacy to be destroyed in the correct manner. Those people who were able to administer their own medicines were provided with a lockable container in a lockable drawer in their bedroom. A risk assessment was undertaken to ensure this was safe.

All staff received safeguarding adults training. They referred to this as protection of vulnerable adults training. The training was part of the mandatory programme all staff had to complete and update on a regular basis. The staff we spoke with were aware of their responsibility to protect people from being

harmed and had a good awareness of safeguarding issues. All staff said they would refer any concerns to the registered manager or the senior member of staff on duty. Some knew they could report directly to the local authority safeguarding team, the Police and the Care Quality Commission.

We asked the registered provider if we could see their safeguarding policy but there was difficulty finding this. When it was located it was named a 'Complaint and Protection' policy. The service had no separate safeguarding policy. This meant staff did not have easy access to information they may need.

The registered manager did not demonstrate a clear understanding of the safeguarding reporting protocols. She would benefit from receiving safeguarding adults training with the local authority. The safeguarding log we were shown had two entries – one was in respect of a person who was not using the care home service (no requirement to notify) and the second was in respect of a medicine error. The second event had not been reported to the Care Quality Commission. The registered manager was unclear of the differences between safeguarding people and the Deprivation of Liberty Safeguards.

This was a breach of Regulation 13 of the Health and Social care Act 2008 (regulated Activities) Regulations 2014.

Risk assessments were completed for each person in respect of moving and handling tasks and falls, and for some, swallowing and the risk of choking and a self-administration of medicines assessment. The moving and handling risk assessment resulted in a plan of care being devised. These set out the number of staff required and any equipment required. Personal emergency evacuation plans (PEEP's) had been prepared for each person. These were displayed in some people's bedrooms but not all. The service did not keep a copy of all of the PEEP's together, near the fire panel to be referred to in the case of a fire. The PEEP's were not rated in order to identify those people who would need the greatest support in an emergency.

The fire risk assessment for the premises we were shown had been completed in August 2007. Recordings made on the document indicated that the assessment had been reviewed on a yearly basis. The level of detail in the report was minimal and may be inadequate. The registered manager told us they were waiting for one of the fire doors to be replaced – there were no dates for the work to be completed. A set of generic risk assessments had been completed regarding the premises and these were all reviewed annually by the registered manager.

The service had an emergency plan in place. This set out what to do if there was adverse weather or loss of utilities. The registered manager had set up a supply of 'emergency equipment' and all staff knew where this was located. Equipment included small camping type cookers, powerful torches and first aid equipment. The service is located in an isolated rural area and in bad weather could potentially become cut off.

There was a maintenance contract set up to service and maintain all lifting equipment. There was a programme of checks to be completed on a weekly or monthly basis and records confirmed that these had consistently been completed. Checks of hot and cold water temperatures, the fire alarm, the call bell system and the emergency lighting system were included in this programme. All checks were signed off as having been completed by the registered manager. These checks ensured the premises and equipment remained in good working order and were safe.

Staff files were checked to ensure that safe recruitment procedures were followed. The measures in place prevented unsuitable staff being employed. Each file evidenced that appropriate pre-employment checks had been undertaken. Disclosure and Barring Service (DBS) checks had been carried out for all staff

(previously called CRB's). A DBS check allows employers to check whether the applicant had any past convictions that may prevent them from working with vulnerable people. There had been very little staff turnover since the last inspection.

Staffing numbers were based upon people's care and support needs. At the time of our inspection there were four people whose permanent home was at Yercombe and five people who were resident on a short stay 'respite' basis. The registered manager adjusted the number of staff on duty for each shift when the need arose. This could be because someone had end of life care needs or they were unwell. Those staff we spoke with said the staffing numbers were sufficient. At the time of our inspection there were four care staff on duty in the morning and two in the afternoon and evening. Overnight there were two members of waking staff on duty. Because one person had just returned from hospital, the staffing numbers had been increased in the morning. The staff team was stable with many of them being long standing employee's. Agency staff were only ever occasionally used, the agency would only ever be asked to supply workers who knew the service. The care staff team were supported by housekeeping, catering, administration and maintenance in meeting people's daily living needs. People were therefore looked after by staff who were familiar with their needs and preferences.

Is the service effective?

Our findings

People received the care and support they needed and their individual needs were met. Comments we received included, "I have been here a long time and get all the help I need", "They help me get washed and dressed", "Some days I need more help than others" and, "I am asked if I would like to have a shower but I would prefer to have a bath". Two people we spoke with said, "We come here regularly for a rest and to recharge our batteries".

Despite this positive feedback from people using the service we found there were significant improvements that the registered provider and registered manager must implement to ensure people's rights were protected.

People were assumed to have capacity to make their own decisions about their day to day life. Staff understood their obligation to support people to make their own choices and decisions. During the inspection we heard the staff asking people to make choices about drinks, where to sit and whether to return to their own room for example. As part of the assessment of needs, people's comprehension and understanding was checked and their care plans stated the need to ask for consent before supporting the person.

The provider had policies and procedures on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). MCA legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves. DoLS is a framework to approve the deprivation of liberty for a person when they lack the capacity to consent to care or treatment.

The registered manager did not demonstrate a clear understanding of DoLS legislation and how this applied to those people who were resident in the service. Information provided by the registered manager prior to the inspection was there was one person subject to a DoLS authorisation however, the Care Quality Commission had not been notified of this. The registered manager said at the time of the inspection there were two people who lacked capacity to make decisions, one because of a short term infection and the other for long term health reasons. The registered manager was uncertain whether an application was being processed by the local authority. The registered manager and care staff completed an online training programme about MCA and DoLS and consideration should be given as to whether this is sufficient for the registered manager.

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

Staff had a programme of training to complete in order to have the necessary skills to meet people's care needs. New staff would have an induction training programme to complete within the first 12 weeks of their employment. An induction training checklist was used to ensure all parts of the programme were completed. The service had recently taken on one new member of staff, the first for a long time. The service had not implemented the new Care Certificate, introduced in April 2015. The Care Certificate covers a set of

standards that social care and health workers must work to. Induction and on-going mandatory training included fire safety, moving and handling, infection control, food hygiene, first aid and safeguarding.

All care staff were encouraged to undertake health and social care qualifications. At the time of our inspection 14 out of the 20 care staff had a level two or above NVQ or diploma in health and social care.

Staff received regular support from the registered manager and confirmed supervision sessions took place three or four times per year. The registered manager and the deputy undertook these sessions and in addition held staff meetings. The majority of the staff team had worked together for many years and were supportive of each other. One staff member told us how the registered manager had supported them during a period of ill health when they had been unable to work. A handover report was given to the care staff starting their shift and this meant that any changes to people's needs were passed on.

People were provided with sufficient food and drink. There was a five week menu plan in place and these were aligned to the seasons. At midday there was an option of two meal choices however, alternatives were made available when neither choice was wanted. On the day of our inspection a pasta bake or a meat pie were the options and one person was served with a fish dish. The kitchen told us menus were changed during the Christmas and Easter festivals and to celebrate other events. The tea time/supper menu consisted of hot snacks, sandwiches and puddings.

The kitchen staff were informed about people's likes, dislikes any preferences and food allergies. They catered for blended meals, fortified diets and diabetic diets were needed. The care staff reported any changes of people's dietary requirements to the kitchen staff.

Most people had their midday meal served in the dining room but the option of having their meal in the bedroom was available. People said this about the food they were served with, "The food is generally very good", "We can ask for a cup of tea any time and the staff are very obliging", "The food is excellent" and, "I like the puddings but then I have always had a sweet tooth". One healthcare professional said, "X has some issues maintaining a healthy diet when at home and has reported loving going to Yercombe because the meals are good". We noted that members of the staff team sat with people during the midday meal and "socialised". People were engaged with the conversations and appeared to be enjoying the interactions.

Those people that were long stay 'residents' were registered with a local GP and would be seen by them as and when needed. One GP told us, "People are all well cared for, look well kept clean and happy" and added they would have no hesitation in placing a family member there if they needed residential care. For those people who were having a short stay at Yercombe, they would remain under the care of their own GP if this was feasible or, the staff would ensure they were temporarily registered with a local GP. A social care professional said that advice was sought from OT's and physiotherapists around any moving and handling requirements. People were assisted to make the arrangements to attend healthcare appointments as and when needed.

Is the service caring?

Our findings

People said, "The staff are friendly", "Everyone is very kind even when I am a little grumpy", "I am very well looked after" and, "I cannot fault a thing about the way I am looked after. The staff respect the way I like things done". Health and social care professionals who provided feedback prior to our inspection said, "The staff are incredibly caring", "The service has a very good reputation" and, "There is a real commitment to providing person centred care for each person and the person's well-being and comfort is seen as very important".

People were smartly dressed and looked well cared for. They were supported to dress in clothing of their own choice and to attend the hair dressing sessions if they wanted. The staff team found out about the things that were important to them prior to moving in to, or staying at the home. One person told us they were able to dress themselves but, "They (the staff) tell me if my clothes don't match and then help me change". The atmosphere in the home was relaxed and people appeared comfortable and confident in their surroundings.

Staff spoke about the people they were looking after in a respectful manner. They told us about the things individual people liked to do and it was evident they liked to take an interest in people's past life.

Staff had positive interactions with the people they were looking after. One person was assisted by a staff member to use binoculars to look out across the countryside and they had a long conversation about what was being looked at. Despite the person having a degree of memory impairment, this interaction brought about remembered life events. Staff spoke to people in a kind, friendly and sensitive manner throughout the inspection and it was evident they really cared about the people they were looking after.

Staff knocked on people's bedroom doors before entering and either waited to be invited in, or paused for a few moments before entering. People's bedroom doors and the doors into bathrooms and toilets were closed when people were receiving care.

It was evident from looking at the care plans that people had been consulted on how they wanted to be looked after and what care and support they required. They were asked about what was important to them and this information was incorporated into their care plans.

The registered manager said the service strived to continue looking after people when they had reached the end of their life and had recently looked after a person who had lived at the home for a long time until their passing. The service worked with the person's GP, district nurses, any family members and other health and social care professionals as necessary in order to provide the care and support the person needed.

Is the service responsive?

Our findings

People were satisfied with how they were looked after and said their care and support needs were met. They said, "I am fairly independent but the staff help me have a bath", "You don't want for anything here", "Everything is first class, I enjoy coming to stay here" and, "My only complaint is I would like to have a bath more often and not be offered a shower. I don't like showers". Healthcare professionals told us, "The staff are always responsive and attentive to any person centred approach needed to aid comfort and wellbeing to the person whilst there".

The registered manager or deputy assessed people's care and support needs before they were offered either a long stay bed or a respite stay at Yercombe. This ensured the service was able to meet the person's individual needs and enabled any specific hoists or specialist beds to be put in place. Where people were part funded by the clinical commissioning group or the local authority information was gathered from them as to the person's needs. These documents identified the type of care the person needed and the level of any risks.

The assessment covered all aspects of the person's daily life and the information was used to write the person's care plan. The care plans were written with the involvement of the person and their relatives where appropriate. They covered the person's personal care needs, mobility, nutrition, continence, skin integrity and comprehension and understanding. The plans were well written and provided sufficient details to instruct the staff on how the person's care needs were to be met.

Care staff completed daily notes for each person. Those records we looked at provided a clear account of the care that was delivered to the person. The recordings were respectful and had each been signed by the staff member making the entry.

The care plans for the long stay people were reviewed on a monthly basis and for those on a respite stay, each time they had a further stay. The care plans were amended as and when needed. People were encouraged to have a say about their care and support and to speak up if they were unhappy about anything or wanted things done differently. The plan for one person who had recently returned from a hospital stay needed to be updated because of the increased assistance they needed with mobility. The registered manager was aware of this. A handover report was given to staff coming on shift. This ensured that important information was shared between the staff and any changes to people's care needs were passed on to the next shift.

The service employed an activities organiser for five hours on a Monday to Friday but they were on leave the day we visited. Group activities were arranged before lunch with individual one to one work sessions after lunch. One person told us "I am self-organising, I can arrange the things I like to do". Another person said they liked to watch TV and preferred to spend their time in the smaller lounge. Two people told us they had been introduced to art therapy (adult colouring books) and found it a very relaxing thing to do after lunch. At several places throughout the communal areas pictures were displayed of activities that had previously taken place, for example Christmas and Easter. People's birthdays were celebrated with a homemade

birthday cake at afternoon tea time. The hairdresser visited every other week and there was a church service on a monthly basis.

People were asked to make suggestions about what they would like to do and whether they had any concerns. They told us they felt they would be listened to and "everyone bends over backwards here to make sure everything is alright". People were provided with a copy of the complaints procedure and a copy of this was displayed by the main entrance.

Is the service well-led?

Our findings

Not every person we spoke with was able to tell us whether the service was well-led. One person said they thought the service was and, "The manager was very organised and efficient". One healthcare professional told us, "The manager is excellent, efficient and offers a great service. I would have no hesitation in suggesting Yercombe as the first place to go for care".

The service had a set of values that included involvement, compassion, dignity, respect, equality and safety. These values were understood by the staff team and by speaking with them it was evident the registered manager ensured the day to day culture of the service was influenced by the proper attitudes, values and behaviours of the staff team. The registered manager or the deputy would see each person when they were on duty and there was at least a daily 'walk the floor'. This enabled them to make an assessment of the premises, to speak with people and the staff team and to check on people who were unwell.

The registered manager was aware when notifications of events had to be submitted to CQC. A notification is information about important events that have happened in the home and which the service is required by law to tell us about. However they were not aware when notifications about deprivation of liberty applications had to be submitted to the CQC.

A quality assurance questionnaire had been used in November 2015 and people who used the service (permanent residents and those having short respite stays) were asked to rate the service in respect of the facilities, the food, the welcome they received, the staff team and the social aspects of life at Yercombe. In general the responses were good or excellent however there had been a score of 'fair' about social activities. One person had commented that the grounds were not sufficiently well used. As a result of the questionnaire no action plan had been put in place. The registered manager said no action had been taken to improve people's satisfaction about social activities.

The registered manager told us they completed a monthly manager's report for the Trustee's meeting. This report provided up to date information about the people using the service, any health and safety issues and statistics regarding bed occupancy. The trustees were not informed about any accidents, incidents, complaints received, safeguarding events or other significant information. There were no records to evidence the trustee's visited the service regularly and met with the people living or staying there and the staff team. There was no evidence to show how the trustee's ensured the service was meeting the requirements of the Health and Social Care Act 2008 and was safe, effective, caring, responsive and well led. The trustee's did not have an adequate programme of audits in place to check on the quality and safety of the service.

We looked at the records of accidents, incidents and complaints. Sixteen falls had been recorded in March 2016 and three people had two falls each. There was no analysis of the circumstances that had led to each of the falls. This meant the registered manager had missed the opportunity to identify any triggers or themes and then make changes to prevent or reduce reoccurrences.

There were two formal complaints logged in November 2015 however, one had been logged as an incident. The registered manager had dealt with one complaint in line with their complaints procedure and the other had been handled by one of the trustees. The complaint had been made by the family of a person who was due to have a three week respite stay but who left after one week. The complaint had been responded to appropriately however, apart from 'record keeping' training arranged for the staff no other actions had been taken. There was no action plan to look at where improvements were needed and to show what lessons had been learnt.

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

The staff team was led by a registered manager who had been at the home for many years. The staff team consisted of a deputy manager, senior care staff and care staff, housekeeping and kitchen staff. The service was supported by the administrator who also supported the day centre run from the same premises. The staff team worked well together with many of them having worked at the service for a long time. Staff all said the registered manager was open and approachable and actively enabled and encouraged open communication.

Staff received a full handover report at the start of their shifts and any changes in people's condition was passed on to them. Staff meetings were held regularly and enabled the registered manager to inform staff about changes, improvements that were needed and who was due to be admitted for a respite stay. Staff said they were encouraged to have a say about people's care and other things relating to the running of the home. 'Resident' meetings were not held as such as there were only four permanent people and up to six people staying on a respite basis. One person said, "We have plenty of opportunity to have our say though and are encouraged to do so".

The registered manager and trustee's kept all policies and procedures under review. These need to be in line with the fundamental standards of care and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and other associated legislation (employment law, Health and Safety etc).

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 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>The registered provider did not ensure that where people lacked capacity to make an informed decision that staff acted in accordance with the Mental Capacity Act 2005. The registered manager had limited knowledge of the implications of the act and the procedures to be followed to safeguard people's rights.</p> <p>Regulation 11(1) and (2).</p>
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>People who use services were not protected against the risks associated with medicines because safe procedures were not followed to ensure they were administered correctly and as prescribed.</p> <p>Regulation 12 (2) (g).</p>
Accommodation for persons who require nursing or personal care	<p>Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment</p> <p>The registered provider did not ensure that systems and processes were in place to ensure people were fully protected from abuse and would be effectively operated as required.</p>

Regulation 13 (2) and (3).

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 17 HSCA RA Regulations 2014 Good governance

The registered provider did not have adequate systems in place to assess and monitor the quality and safety of service provision. There was no plan in place to drive improvements based upon the feedback they had received about the service and events that had happened.

Regulation 17 (2) (b) and (f).