Shaw Healthcare (North Somerset) Limited

Petersfield

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

This inspection was unannounced and took place on 9 and 14 October 2015. At our last inspection in October 2013 no concerns were identified.

Petersfield care home provides accommodation for up to 36 people who require personal care. The service is a residential care home for older people. At the time of our visit there were 33 people living at the home. Petersfield has 36 rooms, it is set over two floors and has four communal lounges, a smoking room, staff room, training room, laundry room, management office, dining area, kitchen, garden and patio area.

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 could be at risk of unsafe care due to not having referrals or actions taken when there were safeguarding concerns. People's support plans and risk assessments did not always adequately detail what support staff might

Summary of findings

provide although staff demonstrated they knew people well. Staff did not always ensure they washed their hands or use personal protective equipment when administering medicines. People who were living with dementia were supported by staff who had not received training or that had a clear understanding of what action should be taken if people did not have capacity.

People and relatives felt supported by staff who demonstrated a kind and caring approach. There was a high use of agency and at times people were supported by staff who were unfamiliar with their care needs. People and staff were happy in the home, and people felt able to receive visitors and walk into the local community should they wish. There was a safe system in place for the recruitment of new staff. Staff demonstrated they respected people privacy and knocked before entering people rooms. People were generally satisfied with the meals in the home although some people found using packs of condiments and sauces difficult. The area manager confirmed they would review this and see what improvements could be made.

People had access to activities and there was an activities co-ordinator who supported people with activities and health appointments. People accessed to the local community and church and there were also opportunities within the home to attend communion. Rooms were individual to people and had personal possessions such as pictures, plants and furniture.

There was a complaints and compliments policy in place. People and relatives felt able to raise concerns should they need to. There were resident meetings that gave people opportunities to give feedback but there was no system to seek, relatives, staff or others who were in contact with the home. Audits were failing to identifying areas of concern such as window restrictors that were unsafe, missing mental capacity assessments and inadequate personal protective equipment whist administering medicines.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of this 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?

Requires improvement

The service was not always safe.

Incidents were not being identified and managed to ensure people were safe and had appropriate investigations and referrals made to the local authorities.

People did not always receive their medicines safely. Due to staff failing to use personal protective equipment and lack of appropriate training for staff who counter signed controlled drugs.

People were not always supported by staff who knew them well, due to the high use of agency staff. People's support plans did not always have guidelines for staff to follow if they became upset or disoriented.

Is the service effective?

Requires improvement

The service was not effective.

People were not supported by staff who had a clear understanding of mental capacity or had received regular supervision and appraisals.

Where people could be at risk of having their liberty restricted no applications had been made to ensure appropriate safeguarded were in place.

People were able to have meals where and when it suited them. Some improvements could be made to people's meal time experience.

Is the service caring?

Requires improvement

The service was not always caring.

People and relatives felt they were supported by kind and caring staff. Most staff knew people well however this was affected by the high use of agency staff.

People and staff were happy in the home and felt able to receive visitors and walk into the local community should they wish.

Staff demonstrated they respected people privacy and knocked before entering people rooms.

Is the service responsive?

Good

The service was responsive.

People received care and support that was responsive to their changing needs. Care plans contained people's current likes and dislikes.

People were encouraged to provide regular feedback at meetings and share their comments about the service.

Summary of findings

There was a complaints and complements policy in place. People and relatives felt able to raise concerns should they need to.

Is the service well-led?

Requires improvement

The service was not always well-led.

The service was not ensuring audits were identifying areas of concern or that there were clear action plans in place to ensure improvements were made.

Where incidents and accidents relating to people occurred the registered managed was not ensuring appropriate action was taken or that the service and staff were leaning from these to prevent reoccurrences happening.

The registered manager was not always notifying us of significant events.

Petersfield

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 9 and 14 October 2015 and was unannounced. It was carried out by an adult social care inspector 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. Their area of experience was older people's care.

Before the inspection, the provider completed 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 looked at the information in the PIR and also reviewed the information held about the service and notifications we had received. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with nine people who used the service, six relatives, six members of staff, the area manager, the administrator and one health care professional who regularly visited the service. In addition we observed staff supporting people throughout the home and during the lunchtime meal. We also inspected a range of records. These included seven care plans, four staff files, medication records, training records, staff duty rotas, meeting minutes and the service's policies and procedures.

Requires improvement

Is the service safe?

Our findings

The service was not always safe. We found during our inspection the registered manager had failed to take appropriate action when required in response to two safeguarding incidents. For example, one person had been found in another person's bedroom partly dressed. The incident had been recorded but no actions had been taken by the registered manager to investigate or raise these safeguarding concerns with the local authority. The person's care plan had no information relating to this risk or what actions had been taken to reduce this from happening again. Another person had gone missing and been found in their house after having a fall. The area manager confirmed, "No action has been taken I am going to review all incidents to see if other referrals need to be made". This meant people could be at risk of unsafe care due to the service failing to identify and have up to date care plans or make referrals when people who are vulnerable were at risk.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us, "I trust staff, I do not feel in any danger" and "I think I am safe here, I did have problems with another resident harassing me, but they have been moved now so it is fine" and "I have a bell and if I call for help someone is here in not many minutes" and "I feel perfectly safe, I leave my doors and windows open, I know if I need something I can press my buzzer and someone will come." Relatives told us, "There is good security, my loved one feels safe" and "My loved one is safe and happy, they are sometimes bothered when another resident who wakes them up during the night, two or three times, but they accept it."

Although staff had received training in safeguarding adults we found actions were not always taken to ensure people were safe. Care staff demonstrated a good understanding of what constituted abuse and how to report it, both within the home and to other agencies. Care staff confirmed they would report any concern initially to the registered manager. They told us, "I would go to [Name] or the area manager" and "I would go to the area manager or the manager." We found the registered manager was not ensuring actions were taken when there were concerns for people's safety.

People had their medicines administered in a timely manner by staff who had received training however when administering medicines staff did not always wash their hand or use personal protective equipment (PPE). Senior staff and team leaders were responsible for giving people their medicines. There was an electronic medicine administration system in place where staff recorded if medicines were administered or refused. This gave staff and managers a clear audit trail of medicines taken. We observed two staff administer medicine whilst not using any gloves or washing their hands. One member of staff touched two people's tablets and one patch for pain relief. At no point did they wash their hands before or after this administration. When asked what protective equipment they used whilst administering medicines, they told us, "I use my gloves for eye drops and creams, but not for tablets." Senior staff confirmed care staff would assist with medicines that required additional security checks. We asked them if care staff were trained, they confirmed they were not. The area manager confirmed care staff had not received medication training and it was only team leaders and seniors who were responsible for administering medicines. This meant staff might not have the skills and knowledge required to identify if there were any concerns relating to medicines that required additional security checks. We fed this back to the area manager, who confirmed they would review this practice.

During our inspection staff used inconsistent practice relating to the use of the 'Do not disturb' tabard, some staff wore it and some did not. A 'Do not disturb tabard' is a tabard that highlights the member of staff is busy and should not be disturbed. When we spoke with staff we had various responses as to why the tabard was not being used. For example they told us, "I find it very hot and I get disturbed a lot more wearing it" and "I am disturbed a lot more wearing it than when I don't it is like a magnet" and "I wear the tabard, we have only just started wearing them." Although we found no medication errors, the risk of this happening was increased by staff not ensuring they were consistent in their practice. We fed back this back to the area manager who accepted this was an issue and confirmed they would address this issue.

At the time of our inspection there were enough staff to meet people's needs although the service was using a high level of agency staff. People, relatives and staff all commented on the high use of agency and how this affected the care provided. One person told us, "It always

Requires improvement

Is the service safe?

seems to be me that gets the agency staff. When I have raised this, I am told the reason I get them is because I can say what I want, I have been unhappy with quite a few of them." Another person told us, "There are a lot of agency staff used, one person yesterday didn't know what they were doing." One relative told us, "They are often short staffed so when [Name] comes home we shower them." Staff all felt that using agency staff had an impact on the care they provided. One member of staff said how they had worked with two agency staff one afternoon. They told us, "Whilst I was preparing scrambled eggs the two agency staff needed some support from me, it was really difficult as I was trying to do tea at the time". The area manager confirmed there was a big recruitment drive happening but they were struggling to fill the care assistant posts. Minutes of the last business meeting confirmed the vacancy shortfalls. The area manager confirmed they always try and get the same agency staff and in response to staff comments were now block booking. During our inspection the area manager confirmed the registered manager had resigned with immediate effect. They had already started to seek a replacement during our inspection.

Some people's care plans did not contain guidelines for staff to follow when they required additional support from staff. For example, three people required individual support due to times when they would become upset and or disorientated. All three care plans had no guidelines or risk assessments for staff to follow in these circumstances. There had been incidents where staff had provided support and reassurance on these occasions Staff we spoke with were all able to confirm how they provide reassurance, however the high use of agency staff meant people could be at risk of not receiving adequate support from staff who did not know them well. We fed this back to the area manager who confirmed they would take action.

During our inspection we identified issues with four windows on the first floor. These windows had restrictors fitted but the restrictors were not fixed to ensure the window was safe as the window could be opened more than a few inches. The provider had not identified these issues which meant people's safety could be at risk. We fed back our concerns during the first day of our inspection this was rectified before our return on the second day.

Some people living at Petersfield were living with early onset to the advanced stages of dementia. There was limited signage or adaptations to the environment to support people living with dementia. For example, not all people's rooms were identifiable through pictures or names. Bathrooms and toilets had small wording that identified them. This meant the environment was not always enabling people to remain as independent as possible.

There was a procedure for the recruitment of staff. For example, two new staff had adequate checks in place before their employment. Their files showed the provider had carried out interviews, obtained references and a full employment history and carried out a Disclosure and Barring Service (DBS) check. A DBS is a check on people's criminal record history and their suitability to work with vulnerable people before they commence employment.

People had personal evacuation plans that detailed support they required if there was an emergency.

We recommend that the service consider the research of current best practice around social and therapeutic activities that benefit people living with dementia.

Requires improvement

Is the service effective?

Our findings

The service was not always effective at ensuring staff received regular training and support or that applications were being made when people could be being deprived of their liberty.

Staff did not always receive regular supervision or an annual appraisal to support them with their personal development. Although staff felt the registered manager was accessible they were not always having regular supervisions or appraisals. The area manager confirmed most staff had not received an appraisal over the last 12 months and it had been highlighted as an action for the service. We reviewed the appraisal matrix it confirmed four out of 36 staff had received an appraisal in the last 12 months. Staff we spoke with also confirmed they had not received an appraisal. They told us, "No I have not had an appraisal" and "I don't know the last one I had". Out of two staff files only one member of staff had an appraisal on their file. This had been completed in 2013. This meant staff were not having the opportunity to receive appropriate appraisals to ensure they had the necessary skills to perform their role.

This is a breach of regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Staff felt supported by the registered manager and happy to talk to them about concerns but were not receiving regular one to one supervision. Staff confirmed, "I have not had supervision recently, I have had one since I have started working here" and "I get support, although I am unsure when my last supervision was." The area manager confirmed supervisions were behind and they confirmed there was a plan to address this action. The supervision matrix confirmed although most staff had received supervision in July and August 2015 their previous supervision session had been months before.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. We asked staff if all people in the home were free to go out of the home, shopping or out for a walk. They confirmed not all people were. We spoke with the area manager regarding DoLS applications. They were unable to confirm what applications had been made and who was unable to leave the care home unsupervised. This meant people were having their liberty restricted and no safeguards had been made to authorise this restriction.

This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Some people living at Petersfield were living with dementia. Although staff confirmed how they support people daily with their decisions they were unclear when a capacity assessment or best interest decision should be made. They told us, "I give choice every day, around what clothes to wear, if they want a cup of tea" and "[Name] has a choice with when they have a bath, we let them decide." We reviewed Mental Capacity Act and Deprivation of liberty safeguards training staff had attended. Only four out of thirty three staff had been trained since September 2014, others dated back as far as February 2010. Staff we spoke with did not have a clear understanding of the Mental Capacity Act 2005 (the MCA) or how to make sure people who did not have capacity were supported to make decisions for themselves and had their legal rights protected. They were unable to identify when someone might not have capacity and confirmed everyone has capacity. For example they told us, "If they have capacity about their own rights, best for the resident it is their choice. If someone lacked capacity I would report it to care connect." We were unable to speak to the registered manager regarding their understanding of the Mental Capacity Act, but the area manager confirmed it was their responsibility to ensure mental capacity assessments and best interest decisions were in place for people. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The area manager was unable to identify any mental capacity assessments or best interest decisions which had been made. They confirmed they would review this and ensure assessments were completed if required.

The policies and procedures did not always give clear guidance in relation to staff training. For example the training policy for the service did not confirm what training staff should have and how often they should receive an update. Staff felt training provided met their needs. We

Requires improvement

Is the service effective?

found not all staff had attended training they could benefit from. For example, end of life training, dementia training and person centred care only a small percentage of staff had undertaken this training. Staff told us, "They send us on training quite a lot" and "All is good, any training I want to do, they are always very approachable". Other training staff had attended was health and safety, infection control, safeguarding adults, food hygiene, control of hazard substances.

During our inspection we observed the lunch time experience for people. We found some areas of improvement which could be made. For example, during the first day of our inspection the menu board displayed the previous days set menu. Condiments were in small one portion packs that some people struggled to open unless they took scissors with them. Some people had to wait due to there not being enough battered fish, although this was quickly resolved. People we spoke with were generally satisfied although some comments included, "I don't like peas so I didn't have them it would be nice to have the options of mushy peas". Recent feedback at the residents meeting highlights some people had made a suggestion to the menu. The area manager confirmed they would review what changes they could make.

People had choice as to where they had their lunch. Some people chose to eat theirs in their room whilst others came to the dining area. People were given choice as to what they wanted to eat as well as drinks. Care plans contained information relating to people's likes and dislikes. Although staff were present people generally ate without staff support. Staff spoke to people whilst they were eating. The atmosphere was calm and relaxed.

People had their own bedroom furnishings including bedding and curtains. Bedrooms contained people's personal belongings such as pictures, photographs, TV's and plants to make them homely. One person had a number of plants which looked well looked after. They confirmed how staff helped to care for their plants. They told us, "[Name] Helps me look after my plants he does them every week".

The home arranged for people to see health care professionals according to their individual needs. People saw their GP and were supported to attended appointments when they needed to. Staff demonstrated during our inspection that they were quick to react when one person became unwell and required medical assistance.

Requires improvement

Is the service caring?

Our findings

Most staff knew people well however some agency staff were not always familiar with people's care needs. Permanent staff demonstrated they knew people well however people and staff felt agency staff were unfamiliar with what care they required. One person told us, "It always seems to be me that gets the agency staff. When I have raised this, I am told the reason I get them is because I can say what I want, I have been unhappy with quite a few of them." Another person told us, "There are a lot of agency staff used, one person yesterday didn't know what they were doing." Staff confirmed, when agency staff are on shift people's comments are that they would prefer permanent staff. For example, staff told us, "It does depend of what sort of agency we get. People don't always want agency people, people will say they want regular staff, saying we don't like so and so. We have fed it back the manager" and "It is much harder work when you are working with agency staff as they don't know people very well, so you end up helping them" and "I have spoken to management about the use of agency as it is really hard going." When we spoke with staff they confirmed what support they provided to people. They told us, "[Name] is very independent likes to have a bath themselves so we make sure they are safe and we leave them to have their bath." This meant people's care at time could be affected by the high use of agency.

People and staff were happy in the home. Staff spent time chatting to people as they went about their work. People we spoke with confirmed how happy they were with the staff employed by the service. People's comments included, "Staff are lovely, I am happy with my care" and "Staff are lovely they can't do enough for me, we have a laugh" and "I am very happy, everything is fine, they look after me well. I have got nothing to worry about" and "Staff are excellent. I cannot speak highly enough of them." Staff told us, "I like working here is it busy but I like it here" and "It is a nice home to work at the only issue is the use of agency staff."

People and relatives felt they were supported by kind and caring staff. One person told us, "Staff are very kind and caring." Relatives told us, "I over heard staff having such a lovely caring conversation with my loved one when they did not know I was there" and "My loved one is very demanding but staff are so good." During lunch time people were greeted warmly on arrival and staff supported people to a table of their choice.

People told us they were treated with dignity and that their privacy was respected by staff. Comments included, "Staff are very kind and caring, my privacy is maintained" and "Staff treat me well, I am happy with my care." During our inspection we observed staff knock on people's door's and await their response before entering. People we spoke with confirmed staff always knocked before entering. After lunch we observed one member of staff support a person who had become unwell. This was done quickly and discreetly, ensuring the person's dignity was respected and care provided was swift protecting their privacy.

People and relatives told us they were able to have visitors and visit at any time. Each person who lived at the home had a single room where they were able to see personal or professional visitors in private. Relatives confirmed how they were able to visit at any time, and were always made to feel welcome. They felt able to take their loved one out for a walk or visit the shops. They told us, "We are able to visit any time. We visit every day for a few hours." Another relative said, "We take [Name] out, we enjoy a walk, the shops are very near."

People made choices about where they wished to spend their time. Some people preferred not to socialise in the lounge areas and spent time in their rooms. People were free to go outside in the garden area or sit at the front of the home on the benches. One member of staff confirmed how one person who had lived at Petersfield was given choice with their diet. They told us, "One person only liked to eat tinned chopped ham, so this is what we gave them as this was their choice."

Staff were able to demonstrate how they respected people's equality and diversity. They told us, "Holly communal visit and one person goes to church on Sunday's" and "One person was a vegetarian so we respected this and ensure they had food they liked to eat." This meant people were supported by staff who were aware of what was important to them.

Good

Is the service responsive?

Our findings

The service was responsive and people were supported by staff who were responsive to their changing needs. For example, one person during our inspection had become unwell overnight. Staff were in contact with their GP and the ambulance service. Part way through the first day of our inspection the person's condition deteriorated. Staff took action to contact the ambulance service and they were admitted into hospital. There relative confirmed, "They are responsive, they don't wait, they will always call us or the GP".

People's care plans included people's interests, likes and dislikes, communication needs. For example, where people had particular routines they liked to follow, these were included in their care plan confirming they liked to eat their meals in their room or liked to get up at a certain time. This meant people had personalised care plans relating to their individual wishes.

People were supported to take part in activities. There was an activities co-ordinator in post who worked Monday to Friday for 30hrs. Part of their role was also to support people to attend medical appointments. There were group activities and individual 1 to 1 sessions for people who preferred to spend time in their room. During our inspection people playing scrabble and joined in with playing cards. Activities were attended by those who were able to join in. The activities co-ordinator confirmed they provide 1:1 sessions for people and trips into the community are undertaken. Trips arranged had been local garden centres and local towns. People had access to the patio area which had raised flower beds. People were encouraged to get involved with planting this area with plants and flowers.

The activities co-ordinator also held resident meetings with people. These were held every other month. Areas for discussion were Christmas activities, including organising a Christmas fair and party. The local school children were planned to visit and sing carols along with a visit from the local Portishead Town Band. Between our inspection visits a resident meeting was held. Feedback was gained at this meeting that people some people wished to have more pasta on the menu. We spoke with the area manager who confirmed they were going to review this request.

The home provided a monthly church service and communion services. Staff confirmed some people attend the local church when they chose to. This meant people were supported and had access to their religious beliefs.

When asked, residents said they would feel comfortable about raising a complaint or concern but none had reason to do so. There was a copy of the compliment and complaint policy in the entrance lobby. No complaints had been recorded since December 2010, there was one recent compliment received August 2015. Relatives we spoke with raised some concerns with us but felt these had been dealt with as they occurred. They confirmed they had always been satisfied with the response from staff and the manager. Concerns varied from the control of temperature in residents' rooms to lost laundry items and wearing other residents' clothing. The area manager confirmed the boiler had been fixed and heating should now be resolved. The laundry assistant confirmed they had spent time sorting out the laundry and storage of people's clothes and bed linen.

People were supported to maintain contact with friends and family. Some people had telephones in their rooms and others had regular visits from family and friends. There was a communal pay phone outside the dining area. On asking staff about this pay phone we were told, "It has been out of action for ages, the manager knows about it." We fed this back to the area manager who confirmed they would action this.

Requires improvement

Is the service well-led?

Our findings

The service was not always well-led. Although the service had a registered manager in post we found during our inspection areas where the service had not benefited from good leadership.

The provider's quality assurance systems were not ensuring they monitored the quality and safety of the service and identified areas for improvement. We found some audits which should have identified shortfalls found during the inspection did not. For example, there was a medication audit completed in June and September 2015 and the infection control audit completed in September 2015 which had failed to identify staff not using personal protective equipment and hand washing whilst administering people's medicines. It also failed to identify lack of training relating to staff assisting with medicines to ensure they had adequate knowledge. The environmental audit undertaken in June 2015 failed to identify window restrictors that were unsafe and there was no other system that identified this shortfall. The care plan audits were failing to identify where people's care plans should have had a best interest decisions in place and possible mental capacity assessments completed.

The provider was aware of some areas of concern prior to our inspection. The area manager confirmed they were aware of vacancy shortfalls, lack of supervision and staff appraisals but there was no action plan in place that identified these shortfalls or that gave timescales to resolve these concerns. We raised our findings with the area manager who confirmed they would address these concerns.

This is a breach of regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The provider was not ensuring there was a system in place so people, relatives and staff were having their views sought outside of resident and staff meetings. Although people, staff and relatives felt happy going to the registered manager there was no quality assurance system to enable the service to gain views from those using and involved with Petersfield. The area manager confirmed there had been no annual survey sent this year. We asked them when the last one had been sent. They told us, "I am not aware of when the last one was sent." This meant there was no system where results were analysed with an action plan in place for improvements to be made. We fed this back to the area manager, who confirmed they would discuss this with head office.

There was a system for recording accidents and other significant incidents however the registered manager was not taking action when required or ensured these were analysed to prevent incidents reoccurring. For example, one person had been found in another person's room. No action had been taken by the registered manager or the service to prevent this from reoccurring. Due to the nature of the concern a safeguarding adult referral was required to the Local Authority, this had not been done. We also found no evidence of any learning to prevent this type of incident occurring again to this person or anyone else. We fed this back to the area manager who confirmed they would review the incidents and take appropriate action as required.

We discussed the issue of notifications with the area manager. We were aware that safeguarding incidents had occurred that had not been reported to us as required. The area manager recognised that this should have been done but agreed that they had not done so.

This is a breach of regulation 18 of the Care Quality Commission (Registrations) Regulations 2009.

The provider was missing opportunities to review the services vision and values due to the lack of supervisions and appraisals. Supervisions are an opportunity for staff to spend time with senior staff to discuss their work and highlight any training or development needs. They were also a chance for any poor practice or concerns to be addressed in a confidential manner.

We asked the area manager what the vision and value was for the service. They told us, "It is to make sure people remain independent as possible. That they receive happy, kind care to ensure their wellbeing. Staff we spoke with also shared this view to ensure people remained independent. They told us, "It is about keeping people as independent as we can" and "It is about their choice."

People and staff told us that they were happy with the service being provided at Petersfield. Relatives told us that they found the staff and management supportive and approachable. One person told us, "We have a good relationship with staff and the manager is accessible and

Requires improvement

Is the service well-led?

approachable. Relatives felt Petersfield was friendly and caring. One relative told us, “People are treated as individuals and get appropriate care which is tailored to their needs.”

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	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People who use services were not protected from abuse through systems and practices in the service or improper treatment. Regulation 13 (1) (2) (3) (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider must have systems or processes established and operated effectively to ensure risks relating to the health, safety and welfare of service users and others are being managed. Regulation 17 (1) (2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People who use services were not supported by staff who received training, supervision and appraisals to enable them to carry out their duties. Regulation 18 (1), (2) a, b,

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person was not ensuring notification were made to the commission without delay as required by their registration.