Mr Paul Bliss

Leonard Elms Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Leonard Elms Care Home provides accommodation for people who require nursing, personal care and dementia for up to 73 people. The home comprises of two units; the Cherries and the Elms. The Cherries unit specialises in dementia care and the Elms unit is for general nursing care. The Cherries unit holds a level three accreditation in the Butterfly Project by Dementia Care Matters. This is a specialist approach designed around entering the world of the person with dementia. On the days of inspection there were 45 people living at the home. The accommodation is arranged in two buildings adjoined by a reception area; one building is for each unit. Most people with dementia were unable to express their views regarding the support they received.

At the last inspection, we found breaches in the home because staff were not receiving regular supervisions or appraisals and there was a shortfall in training. Concerns were found with food preparation areas and chemicals were not being stored securely. Care plans were not complete for people and did not reflect their needs. People were unsafe because there were issues with pressure care and medicine administration. We found the home was not well led because there were no auditing systems in place and they had not identified all the shortfalls we found. Since the last inspection, the provider and registered manager have been sharing changes they had made in the home. Although there had been some improvements, we found there were still concerns.

This inspection was unannounced and took place on the 27, 28 and 29 June 2016.

The registered manager was the acting manager at the last inspection. A registered manager is a person who has been 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. They were supported by a deputy manager, some nurses and team leaders.

People told us they felt safe but there continued to be risks to their safety around pressure care, risk assessments, medicine administration and incident reports. The provider had sourced specialist mattresses for pressure care but these were not always set correctly. People were not being reviewed regularly to ensure their pressure care was relevant. Some people were put at risk if they required special medicine patches. Planned procedures in case of fire were not identifying the risks people could be placed in.

People had a choice of meals, snacks and drinks, which they told us they enjoyed. The chef provided alternative options if people did not want what was on the menu to ensure their preferences were met. However, there were times people's weight was not being monitored and the provider had not identified the risks of choking for people if they required a special textured diet or thickened drink.

Staff were now receiving regular supervisions and appraisals. There had been some improvements with the training staff received. However, staff did not get all the training they required to carry out their duties to

keep people safe and meet their needs.

Staff were aware of their responsibility to protect people from avoidable harm or abuse and most staff had received training in safeguarding. Staff knew what action to take if they were concerned about the safety or welfare of an individual. However, there were no systems in place to ensure all incidents which should be reported were. The recruitment process did not always follow good practice, which meant people were exposed to risk from staff who had not had the correct checks conducted by the provider.

The registered manager and staff had an improved understanding about people who lacked capacity to make decisions for themselves. There had been some improvement in recording decisions made in a person's best interest. However, the correct process had not always been followed for each decision. As a result, people were at risk of their human rights being breached. When they had decided to prevent people leaving the home for their safety the correct processes had been followed.

The registered manager and provider had not followed their legal obligations to notify CQC. The registered manager and provider regularly met. There were now some completed audits which identified shortfalls. However, the systems were not identifying all shortfalls in the home or where some had been identified, actions were not taken in a timely manner.

The provider was in the process of ensuring all care plans had been completed on their new electronic system. Where care plans had been updated there was evidence of people or relatives being involved and good detail for some people. However, not all the care plans had a person centred approach or contained information to ensure people's needs were met. This meant people were not central to their care and decisions they made for themselves or that were made for them.

Staff supported people to see a range of health and social care professionals to help with their care. But sometimes the home had not identified when people who needed to see these professionals. Staff supported and respected people's choices and they knew how important this was.

People and their relatives thought staff were kind and caring. We observed mainly positive interactions. But there were times when staff were only communicating with people to fulfil tasks. The privacy and dignity of people was respected most of the time and people were encouraged to make choices throughout their day.

People knew how to complain and there were good systems in place to manage the complaints. The registered manager and provider demonstrated a good understanding of how to respond to complaints.

The overall rating for this service is 'requires improvement', but the safe domain remains 'inadequate' so the service remains in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.
If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another

inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We made a recommendation the provider reviews national guidance on catering and keeping records for people who have specific dietary needs.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009. We are currently considering the action we are taking.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were at risk around pressure care and there were concerns for people who required specialist textured diets.

People did not always have risk assessments which were required to help keep others safe.

People were at risk of abuse because safeguarding incidents had not always been investigated.

Staff had not always had the correct checks completed during their recruitment to keep people safe.

Staff were able to tell us how to keep people safe and who to tell if they had concerns about people's safety.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff demonstrated some understanding about making best interest decisions on behalf of someone who did not have capacity, but it was not always put into practice or documented correctly.

People were supported by staff who had received some training and supervision but people were at risk because there were gaps.

Most people had their nutritional needs met but there were occasions when people needed special diets which were not provided or understood by staff.

People had access to other health and social care professionals but contact with them was not always made when people required it.

The correct applications were completed for people who were at risk of having their liberty deprived.

Is the service caring?

Requires Improvement

This service was not always caring.

People told us they were well looked after and we saw most of the time the staff were caring. However, there were times when the support provided did not consider people's needs.

People were involved in making some choices about their care.

Most people's privacy and dignity was respected and there were dignity champions to support this.

People's cultural and religious needs had been considered.

Is the service responsive?

Requires Improvement

The service was not always responsive

People's care plans did not always enough detail to make sure staff knew how to keep people safe and meet their needs.

Some people had care plans that were personal to their needs and wishes.

There had been some improvement in the amount of activities available. However, some people thought there were not enough.

People and relatives knew how to make complaints and there was a complaints system in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People were at risk because the provider had not always notified external organisations which could monitor incidents.

The registered manager and provider had some audits, but they had not identified all shortfalls and identified actions had not always been completed in a timely manner.

People were put at risk because the provider and registered manager were reactive when running the home.

The registered manager had a clear vision for the home following a modified version of the Butterfly approach. However, the approach was not embedded in both units.

Leonard Elms Care Home

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 27, 28 and 29 June 2016 and was unannounced. It was carried out by one inspector, two specialist professional advisor nurses 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. One nurse was a specialist in elderly care and the other nurse was a specialist in pressure area care. This was a comprehensive inspection and followed up on concerns from our last inspection in October 2015.

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 also looked at paperwork from the local authority and other intelligence we held internally about the home.

We spoke with 15 people that lived at the home. We spoke with the registered manager, operations manager and eleven staff members, including registered nurses, chefs, activity coordinators, carers and laundry staff. We spoke with seven visitors including relatives and a health worker. We also spoke with a health and social care professional on the telephone.

We looked at nine people's care records and observed care and support in communal areas. We 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 looked at seven staff files, the provider's action plans, previous inspection reports, rotas, quality assurance audits, training records and supervision records, health and safety paperwork, contracts with agencies, minutes from meetings and a selection of the provider's policies.

Inadequate

Is the service safe?

Our findings

At the previous inspection in October 2015 the service was not safe. There was a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because concerns were found in pressure care, medicine management and incident management including falls and risk assessments. Pressure care means proactive actions to reduce the risk of a person getting pressure sores and if they do appear the correct treatment to heal them. The provider told us they had now improved in all areas including purchasing new pressure relieving mattresses and reviewing the medicine management in the home.

At this latest inspection we found there had been some improvements including all medicines administered covertly had been agreed by other health and social care professionals such as a pharmacist and GP. Covert medicines means the medicine has been hidden in a food or drink to ensure a person takes it without their knowledge. Liquid medicines were now labelled when opened and every effort was made to deliver medicines as required Cherries unit. People at risk of pressure sores now had pressure relieving mattresses and some staff had received training in pressure care. Some care plans had been updated recently and some people at risk of pressure damage to their skin had skin inspections being completed routinely. Some incidents had been reviewed by managers and there was evidence actions had been taken.

However, people were still at risk of developing pressure sores because pressure relieving mattresses were not always correctly set meaning for people with limited mobility there was an increased chance of pressure related wounds. Pressure relieving mattresses should be set in line with people's weight in order to distribute it more evenly. For example, one person had their mattress pressure set for someone weighing over 180kg but the person's last recorded weight was 103.4kg. Another person identified as very high risk or pressure related wounds had the mattress on the wrong setting and it did not match their latest recorded weight. A member of staff and a regular agency staff confirmed they had received no training on how to check and set the mattresses. The registered manager explained the mattresses were checked every time the person was weighed by the nurses. Some people had not been weighed for five weeks meaning their mattress setting would not have been checked for this length of time. The operations manager said the manufacturer had provided training to care staff when the new mattresses arrived. The provider was not following the recommendation of the manufacturer to check each mattress to ensure the correct setting for a person at least daily. This is necessary as the settings can be accidently changed by the person, staff and visitors. Following the inspection, the provider provided copies of certificates for 13 staff who had received training from the manufacturer. The provider said the staff who had received training cascaded the main points down to other staff. This was reinforced with a "Do's and Don'ts" document, which was posted in the room of each resident who had a pressure care mattress. The document included information about visual checks on the mattresses, checking the pump was working and how to clean them.

Some people who were not able to move easily were not always being repositioned regularly which put them at risk of pressure sores. For example, one person had restricted movement in their legs which meant their knees were constantly pressed together. There was nothing between their knees to reduce the likelihood of pressure sores developing. A member of staff said the person should have something between

their knees; at no point was this observed. The registered manager explained it would be difficult to keep something between the person's legs. There was nothing in the person's care plan about this concern or actions which had been taken as a preventative measure. The person did have a pressure sore on their ankles. Following the inspection, the provider told us they had encouraged the person to move regularly, but they had refused. The provider had tried to put a cushion between the person's legs but the person often removed it. They understood none of these had been documented, but had now amended the person's care plan. The provider said they had been proactive since the inspection to treat the pressure sore and helped it heal.

There had been improvements in medicine administration but people were still at risk of medicines being missed because staff were not always keeping accurate records. Monthly medicines audit for errors had been completed by the provider for several months and had identified mistakes such as missing signatures on the records and near misses. The medicine audit identified 26 missed signatures between March 2016 and April 2016, two of which were when medicine had not been given to a person. Staff were required to sign medicine records to identify when a medicine had been successfully administered. When medicine audits had identified concerns, action had not had not always been taken to reduce the risks of the mistake occurring again. One audit said, "Missed signature from 14/12/15 to 10/01/2016 still not actioned appropriately". Following the inspection the provider showed us some supervisions which had occurred with staff regarding medication errors. Where actions had been taken these had not prevented reoccurrences of missed medication or missed signatures.

People were at risk of staff not correctly administering some of their medicines such as creams or eye drops. Creams were not clearly recorded on the medicine administration record (MAR) charts. For example, it would say "As prescribed" or "As directed" with a further handwritten instruction to "Refer to the cream chart". These charts were meant to be kept in people's bedrooms but many of them could not be found. One person was prescribed a cream which was to be "Applied thinly for eight-weeks". There was no start date and no record if it had been given and where it was applied. Two other people had cream prescribed for them but no records of whether it had been administered. By not keeping accurate records staff were unable to know whether the administration had occurred as directed by the doctor.

Some people required patches which provided a slow, even release of medicine into their body through the skin. When these patches had been prescribed the MAR chart clearly showed when they should be replaced. However, there was no consistency about the recording of placements of medicine patches. This included some people had no record on the MAR where they had been put or marked on a diagram of the body each time they were administered. This meant people were at risk of the patches being put in the same place each time which could lead to their skin breaking down unevenly. As a result, people were at risk of receiving the wrong dose of medicine because the absorption rate of the medicine could be changed by the uneven thickness of skin. We spoke to the registered manager about placement of medicine patches. The registered manager told us people on the Cherries unit had patches only on their backs so they could not reach them to remove them themselves. They were not able to tell us why the records had not been completed but said they would look into it. Following the inspection, the registered manager reviewed people who required patches to ensure the patch location was being recorded on the MAR charts.

Some people and staff were still at risk of harm because some incidents did not have completed management plans and actions. For example, one person had six falls since March 2016, three occurred in June 2016. Two members of staff were unaware this person had so many falls including the recent ones; one said if they had known they would have contacted the falls team. The falls team are health professionals who provide specialist advice on prevention for people who have recently had falls or at high risk of falls. The other staff member explained the person had used furniture to walk around the home because they

forgot their walking aid. We spoke with the registered manager about actions they had taken in response to the increased falls. They explained some falls were due to an illness and confirmed what other staff had said about the person's walking aid. The registered manager had ordered a piece of equipment for the person's bedroom which would alert staff to when the person was moving around. The person had received input from the falls team when they first moved into the home. The provider had stated the suggestion by the fall teams to prevent falls was not effective but no re-referral was made to them, neither was one made after the increase in falls. This meant the person was at a continued risk of falls and hurting themselves because referrals to specialists had not been made for additional advice and some staff were not aware of recent falls.

People were at risk of choking or swallowing food into their lungs because staff had not understood some people required different food textures due to health conditions. Staff were not able to demonstrate an understanding of the risks related to serving a person food of the wrong texture. Fourteen people required different textured food which we were told by the registered manager and head chef was fork-mashed. Ten people required the different textures due to issues around chewing; no care plans contained rationales about this. Care plans referred to different diets as "soft" or "pureed" rather than using recognised national descriptors. National descriptors have been created so all health and social care staff are preparing food to the same texture rather than an interpretation of what a soft diet means. A nurse told us and records showed three out of four people required pureed food which was a different texture to fork-mashed. There was no difference in the way the mashed or pureed food was served. Some staff poured gravy onto the food which changed the texture further. Following the inspection the provider agreed this should not have occurred and said they would address this. There were other people who required their drinks to be thickened because they had swallowing difficulties. No information was provided for the different stages which should be used. This meant people were at risk of choking from receiving the wrong type of drink. Following the inspection the provider told us there were posters in the food preparation area for different drink thickness types. The provider informed us staff would receive training to reduce risks to people.

People did not have choking risk assessments in place even though they had an identified textured diet. One person had a previous health condition which increased the risk to them further if they were given the wrong diet. We raised our concerns with the registered manager who explained staff had been interchanging the terms pureed and soft. These are different as indicated by the national descriptors. The registered manager said they had printed out the national descriptors for staff to refer to but could not find them and they were not present in any of the nurses' offices. Following the inspection the registered manager told us 10 out of the 14 people needed soft diets for reasons other than choking so a choking risk assessment was not necessary in those cases. For example, people chose not to wear dentures or had difficulty chewing because they had a small amount of teeth. They continued to explain that since the inspection, the home has carried out formal choking risk assessments on the four people with a recognised dietary requirement. The other 10 people had a completed textured diet assessment.

People with specific medical conditions had care plans which informed staff of what to monitor and action to take if the person's condition deteriorated. However, some people with specific medical conditions were at risk of not receiving the correct medical treatment. Not all staff knew how to use equipment to monitor people's health condition or identify when the condition needed other medical intervention. The provider employed assistant practitioners to work alongside the nurses in parts of the home. Assistant practitioners carried out nursing duties under the instruction of a nurse. They required additional support and training to use specific medical equipment. They had not received training and there were no records of competency assessments to check they could use the equipment when monitoring people's health conditions. Following the inspection the provider showed us some training and competency assessments which had been completed for the assistant practitioners.

One person had a specific medical condition requiring their blood sugar levels to be monitored. No normal range was noted in their care plan and their actual readings fluctuated. We asked the registered manager what the normal range was for the person and they could not tell us. They said the person was under the care of their GP. This meant staff would not know whether the readings were normal and safe for this person. Following the inspection the provider told us it was normal for this person's readings to fluctuate.

During the inspection we were alerted by a health care professional to another person who may not have received appropriate treatment. After looking at their records and speaking with staff including the registered manager there were some vital observations missing when their condition deteriorated dangerously. For example, the look of the person's skin because it would indicate certain health conditions. Instead of calling an ambulance the person's GP was contacted. The person had been sent to hospital by the community nurse so they were safe. This meant people with specific health conditions were at risk because not all staff were monitoring their conditions and taking appropriate action.

The provider was putting people at risk in the event of a fire. There were records of completed fire evacuation practices at various times of day. However, on several occasions agency staff had not evacuated the building appropriately. For example, during one fire evacuation practice it was recorded, "Staff attempted to find fire prior to evacuation of the building. Staff did not leave building instead trying to shut off bells". Another said, "Agency upstairs did not know to come down". The operations manager confirmed all entries were referring to agency staff actions. They had a discussion with the registered manager who was unaware of the fire evacuation practice outcomes. Both said they would improve the agency staff induction in the home. Additionally, there was a different staff member managing the fire evacuation practices who would monitor this. The operations manager and registered manager explained during a fire the staff would leave the building and people would remain in their bedrooms to keep them safe behind fire doors. They continued to say, "Our understanding is all care homes leave people in the building during a fire" and explained this was until the fire and rescue service arrived to help with the evacuation. Following the inspection, we shared our concerns about the provider's approach with the fire and rescue service. The fire and rescue service completed a visit in July 2016 and found the home had a satisfactory standard of fire safety. The fire brigade had no concerns about the home's evacuation procedures, which the registered manager told us had been discussed with them in detail.

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

At the last inspection in October 2015 the provider was in Breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Concerns were found around the storage of dangerous substances, food storage, conditions of the home and missing fire extinguishers. The provider told us they had made improvements in all areas including creating a new food serving area in the Elms Unit. At this inspection we found there had been improvements because all dangerous substances were stored securely. There had been refurbishment of a food serving area where the fridges and freezers had been relocated plus the dried food. All these pieces of equipment were clean. The provider had installed two new wet rooms to replace some bathrooms. All fire extinguishers were now correctly sited. There was still some work to be completed on the general décor of the Elms Unit, but the structural work which provided hazards to people had all been improved.

During the inspection there were a large amount of flies in the home. Staff and people were being affected by the quantity of flies. For example, they were seen landing on people who were unable to brush them away. There were a number of methods being used to reduce the flies including fly paper, nets over people's beds and electronic units. The registered manager and operations manager explained their home was

between two farms which they believed to be the sources of the flies. They told us this year appeared to be worse than usual. The operations manager showed us communication with the local environmental health department to try and rectify the problem. On the second day of inspection an air conditioning unit was fitted in the Elms unit. It was hoped the area could be kept cooler without needing the windows open to further reduce the risk of flies.

People and their relatives thought the home was safe. People said, "I feel safe here" and "Yes, I feel safe here". Another said they were "Fairly safe". A relative said, "I feel [name of person] is safe here". A second relative explained an incident which had occurred placing their family member at risk was satisfactorily resolved. Most staff understood how to keep people safe and knew who to escalate their concerns to.

Most incident reports had a front sheet where actions taken were recorded. We found three instances where this had not happened. The registered manager said the staff member had not shared this incident with the nurse so they were unaware of it; this was why there was no front sheet on the incident report. During the inspection the registered manager introduced a new system so staff would show them each incident report before it was filed. The local authority safeguarding team had also not been made aware of this incident as they should have been. The registered manager told us they had employed a new member of management who had been responsible for completing the required actions; they had subsequently left the provider's employment. The registered manager had not completed any additional checks of the safeguarding incidents. This meant systems and processes in place to protect people from abuse were not operating effectively. Following the inspection we shared our concerns about the reporting practices to the local authority safeguarding team so they could monitor if people were kept safe.

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

At the previous inspection concerns were raised about the level of agency staff being used to ensure appropriate staffing levels were maintained in the home. Since the last inspection there had been a reduction in the number of agency staff being used. Their PIR had explained actions which had been taken to achieve this reduction. There was still use of some agency nurses and carers mainly to cover staff sickness and holidays. The registered manager and operations manager agreed some agencies provided better quality staff than others. A member of staff explained they felt there was sufficient staff in the home. The registered manager said they implemented additional staff if required to meet people's needs. The operations manager explained they had another home which could provide some staff including nurses.

A person explained there is "A rapid response" when you use a call bell and another told us they were answered quickly. During the inspection we observed call bells were answered within three minutes of being rung. This meant staff were responding quickly to meet people's care needs and keeping them safe if they required immediate help.

Risks to people were reduced because there were some safe recruitment procedures for new staff. New staff had reference checks from previous employers and there were DBS checks completed. A DBS check is to make sure staff do not have a criminal record and are not barred from working with vulnerable adults. However, there were some discrepancies in staff files. For example, some members of staff had reference requests with no identification it was from the previous company they had worked for. The provider or registered manager had not checked it was their previous company. There were staff members who had small gaps in their previous employment history on their application form but no record of why. The provider had employed a new member of staff to oversee employment issues such as recruitment and payroll. This member of staff explained they knew the staff files needed reviewing and would be completing

this as soon as possible.

Recently there had been a safeguarding incident in relation to a member of agency staff putting people at risk. People were kept safe because the registered manager had been in contact with the local authority safeguarding team and the police. The registered manager said they had not seen the employment checks completed by the agency only spoken about them on the telephone. In the agency's contract signed by the provider it stated "Where such information is not given in paper form or by electronic means it shall be confirmed by such means by the end of the third business day…" The registered manager said she had not followed this contract agreement up. The operations manager and registered manager confirmed they had learnt from this incident. They told us they would make sure in future information about all agency workers recruitment would be received in writing. This meant the provider was not always following up agreed contracts with agencies to ensure employment checks had been completed to keep people safe.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection in October 2015 there was a breach in Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This was because concerns were found in relation to Deprivation of Liberty Safeguards (DoLS) authorisations not being applied for when they were required. Since the inspection the provider had informed us all DoLS applications had been made for people who required them.

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.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the 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 and whether any conditions on authorisations to deprive a person of their liberty were being met.

At this inspection, there had been an improvement at the home because applications to the local authority had been made for all people who required DoLS. Most staff demonstrated some understanding of the MCA and DoLS when we were speaking with them. Some care plans demonstrated the principals of the MCA had been considered for specific decisions. For example, one person who required covert medicine had a capacity assessment and best interest decision recorded including who was involved in making this decision on their behalf. However, staff were not consistently applying the principles of the MCA for every decision when the person lacked capacity. For example, one person had a stair gate across their bedroom doorway to keep them safe from other people entering their room. There was no capacity assessment to show if the person could consent to this or not. There were no best interest decision making documents in the person's care plan to show this was in the person's best interests and was the least restrictive method as possible.

Another person had the following statement written in their care plan, "[Name of person] is unable to make decisions that effect [their] life and wellbeing". They had a DoLS authorisation in place, but no other decision specific capacity assessments or best interest decisions recorded for key parts of their life such as medicine administration and end of life decisions. A member of staff told us they were trying hard to make sure everyone's care plan was correct. A third person had bed rails in use but there was no best interest or capacity assessment for the decision to use them. This meant even though staff had received the correct training and had more understanding they were not applying it correctly for every person. People were still at risk of having their human rights breached because the principles of the MCA were not always followed. Following the inspection the provider said it accepted observations from the inspection. They would continue to ensure staff carried out decision-specific mental capacity assessments and best interests

decisions to ensure that people's human rights were protected.

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

At the previous inspection in October 2015 there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff training records did not correlate with staff files and there was a lack of training in MCA and pressure care. Supervisions and appraisals were not being conducted regularly and in line with the provider's policy. The provider told us since the last inspection all staff had now been trained in MCA and DoLS. All pressure care training had been completed. They explained other mandatory training such as safeguarding and moving and handling had been scheduled throughout the year.

At this inspection there had been some improvements. Supervisions had been completed for all staff regularly and all appraisals had either been held or were planned. The provider and registered manager had introduced a new type of supervision which was responsive to meet the needs of staff. The registered manager explained the purpose was giving good feedback as well as highlighting areas for improvement. They told us this appeared to have had a positive effect on staff morale and performance.

A member of staff told us they were now undertaking a specialist health and social care qualification. Another informed us they had started working through the Care Certificate. The Care Certificate is a set of standards social care and health workers follow and is the new minimum standards which should be covered as part of induction training. Most staff had received training in MCA and DoLS which was highlighted by a greater understanding from staff. Some staff had received pressure training and training from the manufacturers of the specialist mattresses.

However, people were still at risk of harm because not all staff had received pressure care training or first aid training including basic life support. Agency staff and new staff had no information about the mattresses passed onto them during inductions. One member of staff told us they had received no training on arrival and just completed one shadow shift. According to staff training records 16 out of 55 staff had not received training in pressure care and wound management. During the inspection the impact on people included incorrect mattress pressure settings, incomplete body checks and the principles of the MCA not being followed. This meant staff training was not effective in ensuring staff competence was maintained.

The training records showed 31 out of 64 staff had not received first aid training. The registered manager and operations manager were unable to confirm what the first aid courses which had been completed covered; so there were no records of who had been trained in basic life support. The assistant practitioners were administering medicines after completing a short course and training workbook. This had limited information on certain types of medicine such as creams, eye drops and medicines which require additional checks. There were no records of completed competency checks to ensure they were managing medicines safely. This meant people were at risk as staff were not appropriately trained to identify when people were deteriorating or administer medicines safely. Following the inspection, the provider showed us competency checks which had been completed for the assistant practitioner.

There were people who could put others at risk because they had specific support needs around behaviour. Their care plans did not always contain adequate information to inform staff how they can proactively reduce these. Only six members of staff had been trained to work with people with behaviours which could challenge. One member of staff was heard saying how impressed they were when observing another staff member defuse a situation with a person. The member of staff responded by explaining they had learned

this by watching other experienced staff managing similar situations. A health professional told us they thought staff required training on supporting people with specific health conditions, especially with regard to their behaviours. This meant staff and other people were still at risk because not all staff had received appropriate training in positive behaviour support. Following the inspection the provider explained that they were continuing to improve people's care plans, including in relation to supporting people who exhibit behaviours that challenge. The registered manager told us they had identified this as an area staff required supervision through their supervisions. They had organised training for staff with health and social care professional on managing behaviours which challenge.

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

People had mixed views of the food being served at the home. Some people said the food was "Very good" when they were asked. Others said, "The food is alright" and "Not overstruck of the food". Several relatives told us their family members had put on weight since moving to the home.

We observed six people were sitting round a table in the Elms unit; four of them were animated and enjoyed their meals whilst two did not interact at all. One of them did not like their food but a staff member had encouraged them to eat. They had chosen their meals the day before and could change their mind, but there were no menus to remind them of the choices. In the Cherries unit staff supported people positively. Staff members took two plated meals to each person so they could choose which they wanted. This was because they were unable to remember a choice from the previous day. When two people expressed they did not want either option they agreed to cheese on toast offered as an alternative by staff. This was prepared freshly for them and brought by staff. Throughout the home staff members assisted people with their meals in their bedrooms. Staff sat with people, explained what the meal consisted of and encouraged people to eat at their own pace.

However, people who required specialist diets were not appropriately catered for. Some people in the home were meant to have fork mashed or pureed food. Moulds could be used to make these meals more visually appealing. They would help people identify food as it kept each element separate in shape. The head chef told us they had some moulds in the home. During the inspection no moulds were used to serve the specialist diets.

People were at more risk of not eating or drinking enough because records were not accurate. Food and fluid charts had not always shown the amount the person had actually eaten or drunk. There were some records saying the food or drink was offered but refused. However, there was no information whether alternatives had been offered. Fluid charts had not always been tallied at the end of the day. This meant staff were not always monitoring if people had received enough to drink. There was no information to say whether concerns about people not eating or drinking enough had been looked into. Following the inspection the provider explained a dietician had visited the home regularly. During their visits they had told a member of management with only one exception, all of the people she provided support to had maintained their weights adequately since their last visit. The provider explained the dietician felt two people no longer needed to be under their care.

We recommend that the provider reviews national guidance on catering and keeping records for people who have specific dietary needs.

Some people saw health and social care professionals when they had additional health needs. A person told us they were being taken to the dentist by a member of staff. A GP visited every two weeks so any health

concerns could be raised with them. A member of staff told us about a referral to a GP when they found a person unwell. They liaised with them to get this person into hospital. Other people saw specialists if they had complex needs. When there had been noticeable changes in one person contact was made with a specialist so their medicines could be reviewed.

Requires Improvement

Is the service caring?

Our findings

At the last inspection in October 2015 there were occasions when people were not being supported by kind and caring staff members. At this inspection there had been improvements but there were still occasions when staff were not respecting people's privacy and dignity. Most people said they were supported by kind and caring staff. People said, "Staff are kind" and "Love 'em all" when asked about the staff. Another person said it was "Like being in heaven". One person said staff "Tell you where to sit" so they were not given choice. The relatives said, "Staff are excellent", "Staff are very approachable and friendly" and "Staff are lovely can't fault the care".

Most people were greeted by staff as they walked past and they spoke kindly to them. People who required transfers using special equipment between two places had staff explain what they were doing. Staff members checked the person was comfortable during the transfer and provided reassurance if it was required. In the Cherries unit lounge there was lots of positive interactions with people. Staff checked people were alright if they looked distressed or confused. On another occasion staff had a joke with people about the wine not being up to standard in the bar. People responded positively to the jokes by joining in and laughing with the staff.

However, one person in the Elms unit received no interaction from staff for three hours despite becoming distressed and confused. We raised our concerns with staff so a member of staff did comfort them. Later the same staff member supported them kindly at lunchtime. Other people in the same lounge had little interaction with staff except when they were offered a drink. They were left sitting in front of the television even though one person said to staff they could not see it properly. Another person was supported by a member of staff at lunch with minimal interaction; it took eight minutes for them to assist the person with their main meal. The member of staff ignored a request from the person for different food. They were inappropriate when the person spat out some food by saying "Thanks [name of person]". Once the person had finished eating the member of staff just walked away. The member of staff told us they had never received any training in how to support people who had difficulty with eating.

Most people's privacy was respected and all personal care was provided in private. Personal care is when people are unable to complete tasks such as washing and dressing without support. During personal care people and staff told us they were kept covered to maintain their privacy and dignity. Staff knocked on people's doors and greeted them when they walked in. In the Cherries unit, when staff members identified people required personal care they would redirect them to a more private area or their bedroom. However, there was an occasion when a person's door was being propped open with a cleaning trolley. The person was in bed with few clothes on so anyone walking down the corridor could look in; there was another person walking down the corridor at this time. Once the member of staff realised they closed the bedroom door.

The registered manager told us about two new dignity champions in the home to promote the ten principles of dignity and respect. The ten principles of dignity in care were created in conjunction with a number of key organisations such as Age UK and the British Institute of Human Rights to help improve the quality of care.

There were poems throughout the home about dignity and respect to help staff and people reflect.

There were ways for people to express views about their care, but some people were unable to participate in their care. When this was the case their relatives were consulted. For example, one person had a change of needs due to recent incidents with another person in the home. The registered manager had consulted the relatives who agreed measures to mitigate the risks; these were recorded in their care plan and in place in the home. However, one person explained they wanted to participate in a specific activity. They said this was not being facilitated at the moment.

People told us they were able to have visitors 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. During the inspection people saw their visitors in their bedrooms and communal areas. One visitor was unable to speak with their relative because they were asleep so a member of staff offered to find one of the nurses to update them on their family member. The relative declined the offer but thanked the member of staff for the suggestion.

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 able to choose if they had their own or shared bedroom. We checked they were in agreement with this arrangement. For example, one of person told us "We have been married 68-years" and the other person said, "As long as [name of person] is near". They were both spending time in the same bedroom during the day and one had a bedroom next door to each other at night.

Staff were aware of issues of confidentiality and did not speak about people in front of other people. When they discussed people's care needs with us they did so in a respectful and compassionate way. They often chose to do this in rooms with closed doors so they could protect the person's confidentiality. If the person was in the room when we were speaking with them they actively involved the person in the conversation even if they were unable to communicate verbally.

Some people's cultural and religious needs had been considered in the home. The registered manager told us about the work with the church. They explained they had made the monthly services more inclusive for both units rather than just the Elms unit. Due to the location of the home there was not a diverse population but the staff team contained more diversity. The registered manager told us this had led to some challenges with people upsetting staff with what they said. They demonstrated an understanding of how to support staff when they became upset because often people had not comprehended what they had said.

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection in October 2015 there was a breach in regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was a lack of activities, there was limited personalisation in care plans, peoples' current care needs were not always reflected in their care plans and wound care plans were not accessible or completed. Since the inspection the provider told us all nurses were used to the new 'Care Docs' system and care plans are all complete. Care Docs is computer based care planning and home management system for care homes. They also told us every person had a named nurse and key worker. A key worker is a designated member of staff who is responsible for a specific person living in the home.

At this inspection we found there had been some improvements. There were more activities being offered. In the Elms unit there were more activities on offer each day and in the Cherries unit they had created a bar. The registered manager told us they were trying to integrate the two units for more activities. For example, a recent party was held to celebrate the Queen's 90th birthday which involved people from both units. There was animal therapy being offered to people by taking a puppy to greet people in both units.

People had mixed opinions about the activities which they could participate in. Several of them said they would like more entertainment. One person said, "The activities are good". Other people said, "I would like more to do" and "Activities not enough". Another person said, "They promised me I could go to the pub for a meal and a pint once a week but they don't". Some people spent much of their time in their bedroom. In both units there were few activities for these people. Other people in the Elms unit were left for most of the morning in front of the television in one of the lounges. When people were brought in to the lounge they were not asked whether they liked the programme or if they wanted a different one.

One of the activity coordinators explained they were trying to develop their role by teaching care staff about activities and how to run them. This was to reduce the reliance on two activity coordinators; both of them worked part-time at the home. They had made a request to the registered manager for a designated staff member to work at the weekend to provide activities. There was a second community vehicle being organised so more people could participate in activities away from the home.

Most people in the Cherries unit had personal information on the doors to their bedroom including their previous careers and important people in their lives. Some care plans contained most of the details of the person and were person centred. For example, one person with complex needs including a significant learning disability had a detailed life history. Information about their care needs for a specialist type of feeding was detailed and was informative for staff. There was a detailed plan in line with a specific medical condition. However, the same care plan lacked details about a specialist machine in their room including no risk assessment or information about its use. There was a note in the person's bedroom from a speech and language therapist reminding staff about the need for oral care which advocated the use of mouth sponges. Their care plan stated "Do not use mouth sponges because of the risk about the person biting them off and choking". The bedroom note from 2014 had not been updated in line with changes in the care plan which correctly identified the risk of choking. This meant the person was at risk of harm because bedrooms were

not always checked when care plans were updated.

There were still inconsistencies in the records being kept for people with pressure sores. For example, one person had "skin inspection guides" in place which were used to document areas of risk being checked. The first one was from February 2016 and the last was from April 2016. There were no further checks after April 2016 but the risk to the person had not changed. Another person had a wound care record completed in March 2016 because they had a pressure sore. We asked a member of staff if there was any other information or records and they said there was not. The person still had a pressure wound. There was no wound care record for the provider to monitor their pressure wound treatment. A third person had a wound care record which had not been completed since December 2015 and the last entry in the wound progress notes was dated October 2015. The person still had a wound on their foot but no wound care record to monitor the progress or inform staff members of the correct treatment. This meant people were still at risk of poor wound care because records about regular checks were not being kept and no one was monitoring these checks.

People were still at risk because assessments in their care plans were not updated regularly so their health needs could not be monitored. For example, one person was at high risk of malnutrition and required thickened fluid. No information had been recorded after May 2016 to monitor their weight or nutritional risk which meant staff could not identify changes. Another person had not had their nutritional and hydration assessment reviewed since December 2015. A third person had a specific medical condition in their past which could have affected their eating and swallowing. There was no risk assessment in their care plan to inform staff about what their needs were. In addition, the person's mobility plan had not been reviewed since January 2016. Their most recent assessment for risk of pressure wounds was in May 2016; it scored them as being very high risk. There had been no review of the mobility plan in line with the May risk assessment. We spoke to the registered manager who knew there was still an ongoing process of reviewing and updating all the care plans. They explained a nurse had now been assigned to ensure all people's care plans were accurate and updated so their health needs could be met.

When people lacked the ability to communicate their needs and preferences some care plans were not complete or did not provide necessary information for staff to care for them. There were people who had no advanced planning within their care plan. Advanced planning is when someone makes future decisions about their healthcare needs in case of old age or a medical emergency. For example, one person had "Does not wish to discuss" written on Care Docs about advanced planning; this person had an on-going health condition which meant they lacked the ability to make complex decisions now so lacked the capacity to express their advanced plans. There was no indication anyone else had been consulted on their behalf about these plans. Following the inspection the provider told us some people had no family who can be consulted. When possible the provider sends requests to families for such information and about half are willing to provide it. The provider respects people and their families' wishes if they do not wish to discuss such matters. Another person who lacked capacity had no information for staff about their religious wishes other than they were from a Church of England background. The person lacked capacity to tell staff whether they wanted to attend the monthly church services in the home. The care plan did not inform staff how they should support this person's religious needs and whether the person should attend the monthly service. This meant people were at risk of staff not knowing their needs especially if new or from an agency. Following the inspection, the provider told us it does ask families if they think people would like to participate in religious services.

Therefore, the provider remains in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The nurses were responsible for ensuring the care plans and paperwork was complete and up to date. They felt they were not given sufficient time to do this because each care plan had taken around six hours to complete. The registered manager and operations manager told us they were allocating administration time to nurses to complete the care plans and other paperwork. They told us they had allocated an additional nurse to provide one-to-one support for those who were struggling to complete care plans. During the inspection some nurses were receiving this additional support and were positive about it.

The registered manager and provider sought people's feedback on the service they received and took action to address some of the issues raised. For example, during the annual resident's and relative's survey there had been a concern raised that people did not know how to complain. The operations manager explained they had provided a resident/relative welcome pack and this always contained the complaints procedure. Following the inspection, the provider told us due to concerns raised in their annual survey, they had sent out the complaints procedure again with the home's April 2016 newsletter. Since the last inspection there had been one formal complaint. The registered manager had recorded the date of the complaint and managed it efficiently and promptly in line with the provider's policy. They had written a full response to the complainant. In addition, the staff survey showed staff wanted improvements to the bathrooms and a bigger kitchen; there is now a new food serving area away from the kitchen and two new wet rooms in place of bathrooms

The registered manager was in the processes of collating compliments the home had received. This included a selection of cards from families thanking staff for the care of their relative. Comments such as "The girls are so kind and dedicated with all the residents' well-being, no matter what! Making the friendly atmosphere quite tangible" and "I just wanted to thank you all once again for all the wonderful care you gave my [relative] during the time [they] were at the Cherries". Another one said, "[They] were always well cared for and happy thanks to you".

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection in October 2015 there was a breach in Regulation 14 of the Care Quality Commission (Registration) Regulations 2009. This was because there was no notification received about the registered manager's absence. At this inspection we found the provider had made the necessary improvements. There was now a new registered manager at the home.

At the previous inspection in October 2015 there was a breach in Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. This was because the provider had not notified CQC of an authorised DoLS application. Since the inspection the provider told us they had notified CQC of all new authorised DoLS.

Prior to this inspection CQC had received four DoLS notifications since the last inspection. There were two the provider said had been sent by fax; CQC had no record of the faxes being received. The provider had not been notifying CQC of all incidents where people were at risk of abuse. Three recent incidents identified as safeguarding in the home had not been notified to CQC as required by law. One had not been notified to the local authority safeguarding team. There was another incident which had occurred where the police had been called and no notification had been made to CQC. The registered manager said notifications had been the responsibility of a new member of staff but they had not checked they were being completed. People were put at risk by the provider not notifying external organisations so they were able to monitor incidents and make sure people were safe.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

At the previous inspection in October 2015 there was a breach in regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was no pressure care policy and an out of date safeguarding policy. There were few quality assurance systems in place and staff were not receiving supervision. Systems were not in place to manage incidents and there were inaccurate and incomplete records for people. Following the inspection the provider told us they had updated policies, all staff were receiving supervision and they had improved the quality assurance systems.

During the latest inspection we found there had been some improvements. All policies had been reviewed including creating a pressure care policy along with new guidance for staff. There had been three surveys sent out to people, relatives, staff and health and social care professionals. The provider had analysed them and found the majority of feedback was positive. The registered manager had been involved in all staff appraisals to show senior staff how to run them. Recently, some systems had been created to review care plans including an audit.

Some audits had been put in place and had identified areas for improvements. For example, there were medicine administration audits which had identified near misses and missed medication. They had highlighted the MAR where the errors had occurred so each incident could be investigated. There were care plan audits occurring, but identified actions did not occur in a timely manner. The registered manager had

delegated to a member of management the safeguarding audits and since they left had been transferred to the other deputy manager. The provider had put an action plan together following the last inspection and demonstrated where they thought improvements had been made. This included examples of the actions they had taken to make the improvements. For example, the improved policies and procedures and the improvements around covert medicines.

Since the previous inspection the management had taken some proactive steps such as carrying out new types of audits. However, the management were not always aware of shortfalls until another agency identified them. When shortfalls were raised the provider and registered manager responded to them. For example, when concerns were raised about the specialist mattresses for pressure care they sourced new ones. When specific care plans were requested on the first day of inspection they had been reviewed and updated by the second day. When
concerns were raised about staff files not containing the correct information there were discussions between the operations manager and registered manager about how they would rectify the problem. This meant at times there was a reactive approach by the management."

People were not being informed about the most recent inspection from CQC on the provider's website. The provider had failed to include the home's current quality rating on their website in line with the law. We spoke with the registered manager and operations manager. During the inspection the provider responded promptly to address this and displayed the quality rating along with a link to the most recent CQC report. However, they had still not displayed the date of publication of the last inspection report. Following the inspection we alerted them to this error. The operations manager said they will resolve the problem but there would need to be communications about what was required with the provider's website designer.

People were still at risk of harm because the registered manager was not aware of shortfalls in the home found during the inspection. For example, they had not identified issues with agency staff not being inducted in all areas of their work including what to do during a fire evacuation. There had been some improvements since October 2015 in care planning but many were incomplete or lacked information staff required to meet people's needs and keep them safe from harm. For example, people who had specific medical conditions did not have safe ranges identified. Risks were not assessed appropriately for some people and where risks had been identified care plans had not been updated. For example, risks of choking or pressure sores. Staff were still not receiving all training required to keep people safe like first aid, supporting people with special diets and working with people with behaviours which challenge.

Following the last inspection the provider supplied CQC with a detailed action plan containing changes and checks they had made. This included rectifying concerns around pressure care and care plans. The provider reported all issues had been resolved. There had been new specialist mattresses sourced along with training from the manufacturer. Other training was provided for staff and the environment had been improved in the Elms unit by creating wet rooms and a serving area. At the beginning of the inspection and in meetings with the local authority the operations manager and registered manager thought all the risks to people had been resolved. However, at this inspection problems were still found with areas the provider thought had been rectified. New concerns had not been found by the provider. This meant people were still unsafe and not always receiving care in line with their needs.

The operations manager had created a new style of provider audit; this reflected the fundamental standards. Fundamental standards are the criteria below which people's care must never fall and all care providers must adhere by law. However, the provider had not identified which audits would cover more high risk areas. For example, the only new style audits completed by the provider since the last inspection in October 2015 were "person-centered care" and "dignity and respect". This meant the completed audits had

not identified shortfalls found during this inspection for when people were at risk of harm such choking or pressure sores.

The provider remains in Breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives felt the service was well led and the management were doing a good job. One person told us "See [the registered manager] in the corridor and feel better just by seeing [them]". Relatives told us "There are email updates for relatives", "They will always phone if any problems" and "[The registered manager] always returns phone calls". One relative did say "The registered manager not always visible as office in Cherries". Staff explained they felt support by management. One told us they could speak to any grade of management. Another said they would not approach the registered manager because they have more important things to do, but they went to the nurses instead.

At the last inspection, in October 2015, it was not clear about the management structure of the home; this was now clearer. The registered manager was supported by the operations manager. In the Elms unit there was a deputy manager and the Cherries unit had a nurse identified as a potential clinical lead. There had been a deputy manager for the Cherries unit but they had left. The registered manager thought they may be replaced with a clinical lead because there was more clinical focus than in the Elms unit. Nurses were employed for both units. In the Cherries unit assistant practitioners supported the nurses. Both units had team leaders and carers overseen by the nurses.

The registered manager was working to create a single culture across both units in the home. They told us they knew the Cherries unit had embedded the Butterfly approach but there was still work to be completed in the Elms unit. The Butterfly approach is in conjunction with Dementia Care Matters; it is an approach of working with people with dementia where you accept the world as they see it. There were positive interactions between people and staff in the Cherries unit. In the Elms unit the exchanges between people and staff were more task-based. All staff in the Elms unit had received appraisals with the registered manager to explore further planned changes to the culture. The registered manager was encouraging staff from the Elms unit to complete shifts in the Cherries unit.

Nurses told us the registered manager had been supporting them with their revalidation. Revalidation is the new process all nurses and midwives in the UK need to follow to maintain their registration with the Nursing and Midwifery Council (NMC). This is to ensure all nurses are following the code of practice to maintain high standards and safe care. The registered manager was a registered nurse and kept their skills and knowledge up to date by on-going training and reading. They were attending clinical study days, helping 'on the floor' and liaised with other health and social care professionals. The registered manager was positive about the support they were receiving from the provider because the operations manager spent approximately four days a week at the home. The operations manager had identified ways of supporting improvements in senior staff.

The registered manager and provider tried to ensure people had opportunities to be involved in the wider community. The activity coordinators and registered manager worked together to hold whole home events. They were building links with a local children's nursery. Sixth form colleges were providing volunteers such as musicians and befrienders to spend time with people. There was a planned increase from one to two community buses. The registered manager said they were trying to be more inclusive with people from both units.

During the inspection there was a relative's meeting in the Cherries unit. It was attended by five relatives and

there was a clear agenda. Minutes were taken at the meeting for relatives who could not attend. Topics discussed at the meeting included activities, fundraising and interacting with schemes in the local community. These reflected the areas of development the registered manager had spoken about during the inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider was not ensuring notifications were being made when required and without delay.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider was not ensuring that people's care plans were personalised and up to date to ensure staff knew how to meet people's individual needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not ensuring where people lacked capacity that assessments and best interest decisions were in place as required by The Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not ensuring that people received safe care and treatment.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider was not ensuring that people were being safeguarded from improper treatment or abuse due to not operating safeguarding procedures effectively.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider was not ensuring effective systems were in place to monitor and identify the quality and effectiveness of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider was not ensuring staff were appropriately trained to undertake their role.