Cherry Lodge Rest Home Limited

Cherry Lodge Rest Home

Inspection report

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Date of inspection visit: 23 July 2015
Date of publication: 28/09/2015

Ratings

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

Overall summary

Cherry Lodge Rest Home provides accommodation for up to 19 people, most of whom are elderly and frail and some, as described by the manager, who are living with mild to moderate dementia. Some of the rooms in the home are shared. At the time of our inspection 15 people were living in the home.

The inspection took place on 23 July 2015 and was unannounced.

There was a registered manager in post at the time of our inspection. The registered manager was also the provider. 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 and associated Regulations about how the service is run. There was a new manager to the home and also a deputy manager. All three were present during our inspection.

Staff followed correct and appropriate procedures in relation to medicines to ensure people received their medicines safely, however there was no guidance to staff for people who may request PRN ('as required') medicines.

Summary of findings

Although people were not having to wait for assistance by staff we observed staff constantly working at tasks with little or no time to socially interact with people. The registered manager had not considered the deployment of staff and the kitchen staff were unsupported.

Care was provided to people by staff who, although competent in their role, were not provided with the support to attend training. Some staff were behind on their training.

Staff did not understand their responsibilities in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Best interest decisions were not made in line with legislation.

People were not provided with a varied or diet or involved in developing the menu's.

Although we observed some good examples of kind care from staff, we found people's privacy was not always upheld by staff.

Activities were not individualised and did not occur regularly. People were not supported to access the community. The environment in the home was not suitable for people living with dementia.

Care plans were not person-centred and not always accurate. It was difficult to identify if people received care responsive to their needs. For example, in relation to specific conditions.

Staff received supervisions and appraisals, but did not feel supported by the registered manager. Staff told us they were demoralised and unhappy.

Staff supported people to access health care professionals, such as the GP or district nurse, however we were told there were times people with nursing needs were admitted into the home.

Complaint procedures were available to people. People and relatives would speak to the manager if they wished to complain.

Staff knew the procedures to follow should they have any concerns about abuse taking place in the home. Risk assessments were carried out for people to maintain their individual safety, however we found the premises was not necessarily a safe place for people to live.

The provider had ensured safe recruitment practices to help them employ staff who were suitable to work in the home.

Relatives were made to feel welcome when they visited.

Quality assurance checks were carried out by staff to help ensure the home was a safe place for people to live. However, the registered manager did not always adhere to the requirements of their registration.

During the inspection we found some breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 always not safe.

Staff followed safe medicines management procedures, although the recording of PRN medicines was incomplete.

There were an insufficient number of staff deployed in the home.

Risks to people were considered to keep people safe, but action had not always been taken.

The provider carried out appropriate recruitment checks.

Staff were trained in safeguarding adults and knew how to report any concerns.

Is the service effective?

Inadequate

The service was not effective.

Staff did not have a good understanding of the Deprivation of Liberty Safeguards and the Mental Capacity Act. People's movements were being restricted without the proper authorisation.

Staff were not always enabled to access training.

The food was not always healthy and people were not enabled to participate in developing the menus.

Staff ensured people had access to external healthcare professionals however appropriate referrals were not always made.

Is the service caring?

Requires improvement

The service was not always caring.

People were not always provided with privacy and we heard one staff member speak to someone inappropriately.

We saw some good examples of caring treatment from staff.

Relatives were made to feel welcome in the home.

Is the service responsive?

Requires improvement

The service was not always responsive.

People were not supported to take part in activities that meant something to them.

It was difficult to identify if people were provided with care responsive to their needs. There were gaps in information in people's care records.

Summary of findings

People were given information how to raise their concerns or make a complaint.

Is the service well-led?

Requires improvement

The service was not always well-led.

Staff felt unsupported by the registered manager.

Quality assurance audits were carried out to monitor the quality of the service but relatives did not have the opportunity to participate in the running of the home.

Cherry Lodge Rest 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 checked 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.

We reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

This inspection took place on 23 July 2015 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of service.

As part of our inspection we spoke with 6 people, 10 staff, two relatives, the registered manager, the manager, the deputy manager and two healthcare professionals. We observed staff carrying out their duties, such as assisting people to move around the home and helping people with food and drink.

We reviewed a variety of documents which included three people's care plans, four staff files, medicines records and policies and procedures in relation to the running of the home.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was because we were carrying out this inspection in relation to some concerns we had received about the home.

The home was last inspected in June 2014 when we had no concerns.

Requires improvement

Is the service safe?

Our findings

People were not cared for by staff who were deployed appropriately. There were insufficient numbers of staff deployed on the day of the inspection and the staff providing hands on care throughout the inspection did not match the information provided by the registered manager. The registered manager told us they calculated the number of staff needed depending on whether or not the home was full. She told us there would be three care staff in the morning and afternoon, the deputy manager and manager.

On the day of the inspection there were two care staff were on duty. The deputy manager had been brought in to act as the third carer as one member of staff had called in sick. The deputy manager told us they were supernumary (an additional member of staff). We did not see the deputy manager consistently acting as a carer. The chef was responsible for all of the meals (and clearing up in the kitchen) as there were no kitchen assistants. They (the chef) told us this meant they did not have time to cook more than one hot meal a day. Health care professionals told us whenever they visited the home they felt there were not enough staff. They said they found it difficult to find staff at times and staff were unable to accompany them around the home which meant they could not immediately discuss care for people.

Staffing levels were not based on people's needs. We read seven people had 'high' and six had 'moderate' physical needs and three people had 'high' and seven 'moderate' health needs. Two of those people required a hoist to be transferred and others repositioned in bed. Records indicated that people who required repositioned were not always repositioned as often as they should be. Staffing rotas showed us that the minimum level of staffing as calculated by the registered manager to meet the needs of people was not always deployed.

Staff had little time to talk to people. We saw staff constantly carrying out their duties. We saw people who required support from staff during lunch time had to wait to be supported whilst staff helped other people. We read from the rotas that laundry and housekeeping staff were only available four or five days a week which meant care staff would have to undertake additional duties at certain times, particularly at weekends when the housekeeper was not working. The manager told us care staff undertook activities with people when the activities co-ordinator wasn't in. However, from our observations throughout the day staff did not provide activities.

Staff told us they felt there was not always sufficient staff. One staff member said, "Management just expect me to cope and so I do. I always put the care of the residents before anything else." Another told us, "If we know in time then we can find cover." The deputy manager told us they should be supernumerary to the floor to do care plans, but most days this didn't happen. A relative told us, "There are a lot of residents, but they all stay in their chairs so probably enough staff."

The lack of appropriately deployed staff was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff followed correct medicines procedures. Each person had a Medicine Administration Record (MAR) which stated what medicines they had been prescribed, what they were for and when they should be taken. There was a signature list to show which staff were trained to give medicines. However, we observed that not everyone's MAR charts contained a photograph. The deputy manager told us this was because she had not had time to print out the updated record and include it in the MAR.

The recording of PRN medicines was inconsistent and people's choice in PRN medicines was not always respected. We saw staff 'note' on the back of MAR charts when people took PRN medicines. These notes did not always make it clear whether people had been offered PRN medicines, or only when they showed signs of being in pain. One person had a note in their care plan stating, 'There is a plan to discuss a different form of (PRN) medicine as she doesn't like taking (the pain relief they are on), but clearly needs to have a continuous medicine stronger than paracetamol'. We were told by the manager and deputy manager this person was now having paracetamol. However, during the medicines round we saw noted on the back of this person's MAR they had been given the medicine they didn't like taking on two occasions.

The deputy manager told us PRN guidelines had all been updated, but they had not had time to include these in

Requires improvement

Is the service safe?

people's medication records. The deputy manager printed off a full set of pictures and PRN sheets for the MAR records during the inspection and told us they would update everything.

We recommend the provider review their system for recording PRN medicines and ensure staff following guidance in relation to people's individual decisions around their medication.

Accidents and incidents were recorded formally and included details of the accident. However possible causes and ways to prevent further reoccurrence were not always included. We read in one person's care plan they had bruising as this was indicated on their body map. However, no further information had been written in to show how this had been caused and whether or not it had healed.

We recommend the provider ensure records in relation to people's accidents are comprehensive and complete.

Medicines were stored and audited appropriately. We looked in the clinical room and saw medicines were stored in an orderly fashion. There were policies available to staff. Staff recorded fridge temperatures on a daily basis to ensure medicines were stored appropriately. Staff knew how to record on a MAR if a person refused their medicines. We were told night staff carried out audits of the MAR charts to check they had been completed properly.

Risk assessments relating to people's mobility, continence, food, skin integrity and personal care were seen in people's care notes. People were weighed regularly and pressure relieving mattresses were checked and set at appropriate levels. However, we found one window on the first floor of the home did not have appropriate window restrictors meaning people may be able to open them sufficiently to climb or fall out. The registered manager has since informed us they have been in contact with the window company. We found there was a persistent smell on both levels and particularly in one area of the home throughout most of the day. Following the inspection the provider showed us the cleaning schedules for the home and their procedures for ensuring carpets were kept free from malodour.

The provider carried out safe recruitment practices. Staff recruitment records contained the necessary information to help ensure the provider employed staff who were suitable to work at the home. We saw evidence of information being obtained, such as references, health declarations, full employment histories and Disclosure and Barring (DBS) checks. DBS checks identify if prospective staff have a criminal record.

Staff had an understanding of the different types of abuse and described the action they would take if they suspected abuse was taking place. They were able to tell us where to find the policy which would give them guidance on what to do. However not all staff were able to tell us of the role of the local authority in relation to safeguarding.

We recommend the provider ensures staff are reminded of details the relevant agencies in relation to abuse.

In the event of an emergency people would be evacuated from the building in a safe way. We read people had individual personal evacuation plans (PEEPs) in their care plans. This gave information to staff on what this person should need in the event of a fire or emergency.

People told us they felt safe. One person said, "I feel safe even in the night, if I'm not feeling well or need something I press the button." Another person told us, "I feel safe knowing that in the night there is always someone awake – I am never on my own." And a further person commented, "There is security people at night walking about and we're being checked on regularly."

Inadequate

Is the service effective?

Our findings

People's rights were not protected because staff did not have a good knowledge of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people by ensuring that any restrictions to people's freedom and liberty have been authorised by the local authority as being required to protect the person from harm. Staff had not carried out proper assessments where restraint was being used. For example, we found no suitable judgement or review for the use of the keypad on the front door. The registered manager and manager told us they were aware they had yet to complete this work and would be starting to look at each person individually. The manager said, "We have started the first stage of everything."

Consent was not being properly recorded. Do not attempt resuscitation (DNAR) forms were found in some people's care plans and we read decisions had been made by relatives. However, staff had not checked to ensure people's relatives had the legal authority to make decisions on their family member's behalf.

The lack of following legal requirements in relation consent to care was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by staff who did not have access to a sufficient amount of training. We saw staff transfer people using a hoist in proficient way. A relative said, "They seemed trained – able to get my father out of his chair easily." However we read staff were behind on essential training such as health and safety, infection control, fire awareness and food hygiene. The manager said she had developed a training programme to ensure all outstanding training was provided to staff over the coming months.

One healthcare professional told us they had concerns as staff did not attend any external training sessions. They had been told by staff this was because the provider did not allow them to take time off for training during normal working hours and staff were expected to pay for their own external training. This was confirmed by information contained in staff files which read, 'You will not be paid for any statutory training provided by an outside provider' and, 'Moving and handling and first aid will be provided by an independent provider and you will not be paid for this training'. We read on the home's website that staff were provided with, 'specialist training' and the provider, 'provides continuous training to its staff' however the registered manager told us that not all staff had received dementia training or training specific to the needs of people.

Staff received supervision and appraisal. The registered manager told us they planned to change the format of supervisions slightly to make them more meaningful to staff. We noted at present supervisions appeared more of a 'tick box' exercise, rather than a way of ensuring staff were putting any training received into best practice and were supported in their role.

The lack of supporting workers was a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were positive about the food. They told us, "The food is very nice and they always say to me you can always ask for something else if you don't want it or don't have it" and, "The food is enjoyable - plenty of variety." One relative said, "The cook will always make an omelette if the main course is not liked."

Despite people's comments we found only one choice of a hot meal on offer for people at lunchtime. The second choice was cold, such as salad, for example. The meals served were small portions and we did not hear people being offered seconds. The hot meal at lunchtime was listed as 'toad in the hole'; however we saw people were served only with sausages. One person commented, "To me that's crap." The cold choice looked a very unappetising salad consisting of mostly lettuce, boiled egg and cold potatoes. One person complained their potatoes were cold and we saw staff heat them up for them.

People were not provided with a wide range of healthy food. Notes from the two residents meetings showed people had raised concerns about the food. We read people had said the meat was tough and there was no fresh fruit being offered. In addition, we saw that people were not offered a snack with their morning refreshment such as a biscuit for example. We saw a folder in the hallway of the home entitled, 'What's in your food'. There was an ingredient list for each dish, but as some meals were frozen the list was the ingredients from the back of the box, for example, the fish and chips.

Inadequate

Is the service effective?

The chef told us that as they worked on their own and as they had to do all the kitchen duties they did not have time to cook another evening meal. However, we noted people were provided with an option of sandwiches, soup, cheese on toast, (tinned) ravioli or sardines on toast. Staff told us people did not get nutritious food. One staff member said, "The food is awful for people." Another told us, "We are looking to change the menus." Further staff commented, "We think the food is awful, it's value food."

People's food and dietary choices were not respected. The chef told us they were given a list of people and their food preferences. They told us one person chose to have a gluten free diet but that they didn't think this was a dietary need. They were not able to evidence to us gluten free foods were available for this person and when we asked staff what bread would be used for this person's sandwiches that evening, we were shown a 'normal' loaf. We spoke with the registered manager about this who told us they would rectify this straight away. During lunch we noticed that around half of the people were given an egg salad. One person asked why they had been given this and was told it was what they ordered. They said they did not remember this but staff did not offer them an alternative.

Healthy options were not available for people. We asked the registered manager if fruit was available for people each day and were told, "I stopped that as I didn't want people wandering around taking a bite out of fruit and then putting it back in the bowl." However, we saw very few people throughout the inspection moving around of their own accord. The registered manager told us strawberries and bananas were available to people, although we did not see these being offered to anyone.

People were not offered snacks or fruit by staff. The drinks trolley was seen at 10.00am and 3.00pm. We did not hear people being offered drinks in between time by staff.

The failure to meet the nutritional needs of people was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff involved healthcare professionals when people's health deteriorated or changed. We read in people's care plans they had involvement from the district nurses, GP, optician and other external professionals.

Requires improvement

Is the service caring?

Our findings

People were not always provided with privacy. During the afternoon we heard one person on the telephone to their relative. At the time another person was calling out to staff loudly. Staff did not make any attempt to move them to give the person on the telephone the privacy to continue with their phone call. We heard the person on the telephone complain to their relative.

People were not always shown compassion by staff. We heard two members of staff speak in a calm manner to one person who had become anxious whilst they were waiting for their new pressure mattress to be inflated as they were eager to return to bed. Staff kindly explained to them the reason for the wait and reassured them. However, we heard one member of staff say, "Stop it, you can stay up a while." We spoke with the registered manager and manager about this who told us they would speak with this member of staff.

We recommend the provider reminds staff of the importance of ensuring people are given privacy and spoken to in an appropriate manner.

We saw some good examples of caring staff. We observed two staff had a very good relationship with people and showed real commitment and care towards the residents. One member of staff was assisting a person and they were taking time and talking to the person throughout.

Staff told us they didn't believe in rushing people and tried to encourage independence. For example, handing a flannel to a person to wash their own face. They told us this helped people feel good about themselves. They added, "I take my time and do the job properly." They told us they didn't use a hoist when people, if they were given time, could move the way they wanted. They said they refused to be dictated by senior staff that a hoist had to be used (to save time). We did not hear this was always the case as one relative told us their father, "Is not allowed" to use their wheelchair to get about as he was not aware of other people.

Staff knew people well and spoke about them in a caring way. We heard staff talk with residents in a way that showed they knew them. Staff told us specific information about people who they cared for.

People said, "Staff are very good, very kind and very patient with me", "Staff are wonderful – bend over backwards. They talk to me properly – respectfully. They are very caring." And, "I am well looked after."

One relative said, "My father likes the carers very much. He says they have a sense of humour and have a joke with him." Another said, "I am very satisfied with the care of my father." And a further commented, "My mother is clean and well cared for. The care here is really good and mum is really happy."

The manager tried to ensure people were involved in some decisions. For example, they had recently reorganised the lounge and dining areas of the home. She told us how she had consulted with people before she did this. She said she was trying to make the home less, "Institutionalised."

Relatives and friends were welcomed into the home and people were encouraged to maintain relationships with people close to them. One relative said, "I have never felt unwelcome and I am offered a drink."

Requires improvement

Is the service responsive?

Our findings

The home's website states, 'Cherry Lodge offers a wide range of social activities and encourages its residents to continue their hobbies and leisure interests within the home'. However, we did not see any of this during our inspection. We read from care records that the last activity, which was a quiz, was two days earlier. The manager told us the activities co-ordinator was on annual leave for two weeks and no replacement had been organised. It was up to care staff to organise activities for people, however we did not see this happen on the day. People wanted more activities. We read people liked quizzes, entertainers and music, but despite raising this at residents meetings, no additional activities had been arranged.

There was not enough to do for people. The manager confirmed this. They told us, "It's a shame because we have a fantastic activities cupboard, but staff are too busy to use the items in there." Music for Health came in once a week and there was usually an activities co-ordinator three times a week. During the inspection we saw people doing very little. We saw people dozing a lot during the day or just sitting. There was a lot of reliance for entertainment on a permanently switched-on television.

People were not always supported to maintain their hobbies or interests. One person did go out to the local day centre three times a week. However a relative said, "There is not much in the way of activities." They told us they had made suggestions to the previous manager in relation to activities for their father. For example, they knew he enjoyed jigsaw puzzles. However, nothing had been organised for him. They told us, "They need more activities; I am concerned my father might be bored." They added their father had never been on an outing and so far he had not been in the garden. We read in one person's care plan staff had written, 'Likes to look at a book. Staff to ensure (the person) has a book'. We did not see staff offer this person a book during the day.

Staff told us there was not enough for people to do. One staff member told us, "People don't go out much. I would never have my mother here, people don't progress because there is nothing for them to do." A further told us people had only been out a handful of times. We spoke with the registered manager and were told, "We have activities every day." (Although we had seen nothing during our inspection). They told us there were no activities at the weekend because more visitors came to the home and people didn't go out a lot because, "It wouldn't be financially viable to take people out on jollies all the time" adding it was a small home and they couldn't afford to employ the number of staff needed to take people out." Healthcare professionals commented there was nothing going on for people and there was not much going on and no life for people.

The environment was not particularly suitable for people living with dementia. Although there were items to prompt people's memories or engage in conversation with staff and others located around the home, we did not see staff encourage people to use or touch them. People's rooms did not have memory boxes and some rooms did not have any form of identification for people, in order to assist them in finding their own room.

Responsive care was not always provided by staff. We looked at the weights of people over the last year and found seven of the 15 people had lost weight. For some people this was a considerable amount. For example, one person had lost 13kg. Despite this we did not find any evidence of staff taking responsive action. For example, referring people to appropriate healthcare professionals, such as a dietician or nutritionalist.

It was not clear whether people received the care they required in relation to their specific condition. Care plans evidenced the involvement from external health professionals to provide guidance to staff on a person's changing needs. One person was diabetic and they required their blood glucose levels taken twice daily. We read in their care plan that on three occasions it was only taken once a day and on one day it was not taken at all.

One person spent most of their time in bed and was on 24-hour repositioning charts with staff turning them every hour or two hours. A second spent time in bed and out of bed, but required turning when in bed. Records showed that on one occasion one person was not turned for a period of 11 hours. On another occasion the records indicated they had not been turned for five hours. And on the day of the inspection one person had not been turned for three hours. One of these people had been prescribed topical cream (cream that can relieve irritation), but there was no guidance for staff on how often this should be applied.

Requires improvement

Is the service responsive?

The health needs of people may not always be met or recorded appropriately. We read one person was recorded as being, 'large' when they moved into the home, despite only weighing 6st 6lb. One person had written in their care plan, 'Requires a standard firm mattress with two pillows' however, we found they were sleeping on a pressure relieving mattress. We asked the deputy manager and manager the reason for this but were unable to tell us why this person was on a pressure mattress.

The lack of personalised person centred care, responsive to people's needs was a breach of Regulation 9(3)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were provided with information on how to make a complaint. We saw people had folders in their rooms which included a complaints policy. This was also displayed in the lobby of the home. People said they knew who they would speak to if they had a concern or complaint. They told us if they had any complaints or concerns they would speak to the manager. We were told by the manager that no formal complaints had been received recently. We noted the complaints policy gave incorrect information of who people could contact should they remain unhappy with the response from the provider. We spoke with the registered manager about this and asked them to update their complaints policy.

We recommend the provider update their complaints policy to include information about the health ombudsman.

Requires improvement

Is the service well-led?

Our findings

The philosophy of the home was not followed and although the provider had responded to people's feedback they had not always taken action to make things better for people. We read on the home's website, 'We listen to our resident's suggestions and ensure that our residents are fully consulted about all matters which will affect their day to day lives at the home'. However, we noted the provider had not always acted on people's feedback. From the notes of residents meetings we read that people had asked for more activities and outings. We read in these notes the provider had told people outings were not possible, 'due to car insurance issues' and, 'transport issues pose a problem'. The provider could not demonstrate to us they had not considered alternative ways to enable people to access the community, such as walks or with the use of volunteers.

Relatives were not always involved in the running of the home. The manager told us relatives meetings were not regularly held and this was something they planned to reintroduce. We noted surveys were carried out with residents and professionals, but these were not provided to relatives. The manager said at present relatives could only email in or speak with staff when they visited.

We read the last quality audits were completed in March 2015. These included health and safety, infection control and maintenance and grounds. We saw that no actions had been identified. The manager was unable to tell us if any more recent audits had been done or how often they should be carried out.

We recommend the provider review their quality assurance systems to ensure they are consistently applied.

Staff told us they did not feel supported. One staff member said they sometimes felt valued, but not all of the time. Another staff member told us they did not feel supported or valued. They said conditions were a bit better, but when they were unwell no-one asked them how they were. They added, "I don't know who to turn to when I need support." Another said they felt unhappy and said they (the registered manager) never told staff anything positive. They commented, "I hear how disappointed she is with staff all the time. She makes me cry." Staff told us they were unhappy, felt unsupported and demoralised. They said they often had to work long hours and did not have time to socially interact with people. Some staff told us they were, "Frightened" of the registered manager. Staff told us the registered manager didn't work in the home and one staff member said the registered manager didn't play an active part in the home. We did not see the registered manager actively involved in the home during our inspection.

The lack of support for staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 18 HSCA (RA) Regulations 2014 Staffing **The registered provider had not ensured sufficient numbers of staff to meet peoples' needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered provider had not ensured staff received the training and support they needed to enable them to carry out their duties.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The registered provider had not ensured care and treatment was provided with the consent of people.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The registered provider had not ensured people were provided with suitable and nutritious food.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered provider had not provided for people's individual needs.**