The Cedars (Weston) Limited

Cedars (The)

Inspection report

8 Clevedon Road
Weston Super Mare
Somerset
BS23 1DG

Tel: 01934629773

Date of inspection visit:
16 October 2019
18 October 2019
22 October 2019

Date of publication:
21 April 2020

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: The Cedars is a residential care home that provides accommodation and personal care for up to 28 older people. People who live at the home access nursing care through the local community healthcare teams. At the time of the inspection 25 people were living at the home.

People's experience of using this service: The provider and senior staff had completed audits on the home to support quality checks. However, these checks had not prevented repeated and new shortfalls in the quality of service provision. The provider had failed to notify the appropriate authorities of safeguarding events and the commission of statutorily notifiable events.

There were enough staff to meet peoples' basic needs. Staff training was provided but did not always ensure people's specific needs were covered. Staff recruitment procedures were not followed appropriately. Staff had not received regular supervision.

Care plans were not consistently person centred and there was a lack of detailed guidance within peoples' risk assessments for staff to follow.

Medicines were stored safely. Some improvements are required in relation to medicine administration and documentation. People had not received access to regular oral health and other appointments.

The service did not provide people with regular access to the local community and activities were lacking for people that did not partake in group activities.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. However, the service had not followed guidance fully when making best interest decisions. We have made a recommendation about this.

People were supported for by a staff team who were kind and caring. Staff had good relationships with people and knew them well.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update: The last rating for this service was Requires Improvement (published 31 January October 2019). The service remains rated Requires Improvement. This service has been rated Requires Improvement since 2016 for over four consecutive comprehensive inspections.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of

regulations.

Why we inspected: This inspection was scheduled based on the previous rating.

Enforcement: We have identified eight breaches in relation to governance, risk assessments, medicine management, recruitment, staffing, the environment, and statutory notifications at this inspection. We placed additional conditions on the provider's registration to enable them to focus on making improvements.

Follow up: We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well led.

Details are in our well led findings below.

Cedars (The)

Detailed findings

Background to this inspection

The inspection: We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team: The inspection team consisted of three inspectors and an assistant inspector.

Service and service type: The Cedars is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service manager has applied to be registered with the Care Quality Commission and is awaiting the outcome of their application. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: The first day of inspection was unannounced. The second and third days of inspection were announced to ensure that senior staff would be in the office to support the inspection.

What we did before inspection: We reviewed information we had received about the service since the last inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection: We spoke with ten people who used the service about their experience of the care provided. We spoke with seven members of staff including the nominated individual, manager, group support manager and care staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included five people's care records and medication records. We looked

at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection: We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Recruitment
At the last inspection we found that recruitment practices were not always safe. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 19.

• Staff recruitment systems were not robust. Four staff recruitment files reviewed did not include a full employment history. For one of these staff members there was also no evidence of an interview or that their competency had been checked prior to their employment. Information gathered for a further staff member indicated potential risk, however this had not been fully assessed prior to their employment. . Another staff member who had been re-employed by the service did not have a new DBS or reference check. Reference checks did not take into account conflicts of interest such as friends already employed by the service providing references for one staff member.

We found no evidence that people had been harmed. However, the failure to ensure recruitment was safe and robust amounted to a continuing breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely;

At the last inspection we found that medicine records were not completed effectively. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection. The provider had now breached regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because it was not just the records which were a concern.

At the last inspection, the management of medicines was not always safe. PRN (as required) medicines did not always have clear instructions for staff to follow that confirmed when to administer these medicines.

People's topical medicine (creams) administration records (MAR) did not contain the frequency of application and the recording was poor.
• At this inspection, people's topical medicines were not always labelled with opened and expiry dates. Daily medicine fridge temperature checks were missing for some days over a period of two months. There were not always topical MAR for all prescribed topical creams. When fridge temperatures were above the recommended temperature for safe storage there was no recorded action taken.

Preventing and controlling infection
• At the last inspection we found one person's mattress, although inside a plastic cover, needed replacing due to being dirty and stained.
• At this inspection, we found that some mattresses and bedding were stained, and some plastic mattress covers were torn. This was an infection control risk as they could not be cleaned thoroughly. There was also an unpleasant odour from two of the mattresses and yellow staining.

Assessing risk; Learning lessons when things go wrong
• Care plans contained risk assessments for areas such as skin integrity, malnutrition, and mobility. When risks were identified the plans did not consistently contain detailed guidance for staff on how to reduce the risks to people. For example, the diabetes care plan for one person was detailed but it did not contain any details on the physical symptoms staff should look for if the person was at risk from their blood sugar levels. Another person living with diabetes had a brief explanation that they had diabetes but no detailed guidance of how this was to be managed. For example, the care plan stated that the person was to be administered insulin once a day in the morning and their blood glucose levels to be checked once a day. There was no detail of timings and whether this should be; before or after food. This person also had other health but no information on how to manage risks associated with them.
•There was no risk assessment in place for a person who smoked in relation to fire risk and emollient skin products that were flammable.
• For one person who had exhibited episodes of challenging behaviour there was no guidance for how this could be managed.
• People were at risk of avoidable harm. There was a monthly analysis of incidents and accidents however there was no falls management in place that identified trends such as the time, location and hazards involved in the fall. Patterns to falls were not established to identify what the trigger for the falls could be. There were no relevant checks in relation to eyesight, medicine, footwear etc. that may help identify a cause for the fall. By not thoroughly analysing these falls the provider had not ensured appropriate measures were in place to reduce these risks.
• Staff told us they did not have time to read people's risk assessments. One staff member said, "Kept in the office, don't really have the time to read them, we could read them on our breaks, but we don't really want to." Another staff member said "No, sometimes I think on the weekend we have time to read care plans, Monday to Friday we don't."

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate medicines, infection control and risk to people were effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Systems and processes to safeguard people from the risk of abuse
• There was a failure to safeguard people. Abusive incidents and allegations of abuse were not always reported appropriately. Staff were able to tell us how they would report incidents of abuse. However, we found incidents had not always been reported. An external review by the local authority identified issues that provided examples of safeguarding incidents. These incidents were not reported to the local

safeguarding authority in line with legislation and the provider's policy.

We found no evidence that people had been harmed. However, the failure to safeguard people by not reporting alleged abuse, and abusive incidents amounted to a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People told us they felt safe and appeared comfortable when staff were present.

Safety monitoring and management
• Systems to monitor the safety of equipment and the environment were not effective. Actions required from a health and safety assessment in January 2019 had not been completed to ensure the service environment was safe. This included fire risks identified in the report.
• Equipment which could be dangerous to people was not stored safely. Open storage cupboards which contained items including; gloves, and aprons used for personal care. Painting equipment had been left in one empty unlocked bedroom. Anyone within the home could have accessed these items; this is a particular risk when people living with dementia are resident.
• On one doorframe leading into the dining room there were large protruding nails pointing outwards. We were told by the manager this door was usually fixed shut. However, on the second day of the inspection, the door was open, and a vacuum cleaner placed across the door way. This did not prevent potential injury from the protruding nails.
• Radiator covers were not properly fixed to walls in some bedrooms. A sliding door to a bathroom in one bedroom was not attached to the floor. This meant that it swung back and forth when grasped and could cause an injury or fall.

We found no evidence that people had been harmed. However, the failure to ensure the environment and service equipment were safe was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing
• Staffing numbers were assessed and determined in accordance with people's needs. We observed that staff were task orientated. Peoples' basic personal care needs were met. However, staff did not spend time with people other than when performing a task or group activity.
•People said, "Not always enough staff I don't think it's the fault of the home just general", "There's not enough staff for one to one," and "Staff don't spend too long with me but sometimes I sit here and don't see anyone for a while." People said that staff attended quickly when called.
• Staff said they did not think there were enough of them despite new staff being employed. One staff member said "We still need more staff, it is progressing [improving]. Another staff member said, "When you check the rota now everything is ok because we have new staff, but they have just started, we've had a big problem with staff."
•Staff said they did not think that staffing was increased when people's need changed and that they were regularly called off rest breaks or did not always take breaks because there were not enough staff to meet people's needs. Staff said, "When we are short staffed sometimes we don't get morning break."

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good . At this inspection this key question has now deteriorated to requires improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
• Staff had not been provided with opportunities to discuss and receive feedback about their individual performance and development. Supervision is dedicated time for staff to discuss their role and personal development needs with a senior member of staff. The expectation of the provider was that each staff member received a supervision six times a year. Supervisions had not been taking place at this frequency. We looked at four staff supervision records, they showed that none of the staff had received a supervision in 2019 although two staff had received an annual appraisal. Due to there not being any supervisions in place the annual appraisals were not based on any documented performance and progress.
• All new staff completed a full induction process. However, one member of staff said that they had not been offered an opportunity to complete the Care Certificate and did not have an equivalent qualification. The Care Certificate was introduced in April 2015 and is an identified set of standards that health and social care workers should adhere to when performing their roles and supporting people. The training matrix identified that many care staff that did not have an equivalent qualification had not been provided with training to complete the Care Certificate.
• Staff received training through the provider's essential training programme which included safeguarding, fire safety, and moving and handling training. Training to help meet people's basic needs such as oral health training had not been undertaken by all care staff. Training specific to peoples' needs such as schizophrenia, learning disability, falls and mental health training had not been undertaken by all care staff to ensure they were able to meet peoples' individual needs.
• Training had not provided to all staff including the manager to enable them to use the system effectively.

We found no evidence that people had been harmed. However, the failure to ensure staff received necessary training and opportunities for supervision amounted to a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• All care plans we viewed had little information in relation to routine health appointments. Records did not identify when people were due to their regular appointments such as at the dentist, the chiropodist and the opticians. We were told by the manager that some people's health outcomes from appointments were recorded in a variety of places such as the handover book, the person's paper daily records, an electronic

care plan record and the service diary. This did not allow for a structured review of people's health outcomes. When asked the manager was unable to tell us how they would be assured they knew when a person's next routine appointment was and the outcome as the information could be in a variety of places.
• Oral health care plans were not detailed. One person's care plan which was last reviewed in July 2019 stated that the person was 'Not registered with a dentist at the moment' there were no further records in relation to when this person last had a routine dental check.
• Every care plan we reviewed stated that people's toothbrushes should be replaced every three months. This was not a person-centred way of evaluating when a new toothbrush may be required. We observed worn tooth brushes with misshapen bristles in people's bathrooms.
• Care records for one person stated they had visited the dentist to have their dentures adjusted. The person's dentures were uncomfortable, and they had trouble eating and chewing. Their care notes stated that if the dentures were still hurting at the end of the week then another appointment would need to be made. There was no further information within the care notes that a dental appointment had been made 14 days after the original entry. Furthermore, daily notes stated that the person enjoyed their meals with no reference to the person's discomfort whist eating or the requirement for their food to be cut up to enable them to eat. We asked the manager to produce any other records in relation to their denture plan or appointments and there was no further information.

We found no evidence that people had been harmed. However, the provider had failed to ensure people's health needs were monitored effectively and that appropriate health referrals were made. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
• People at risk of not eating and drinking enough to maintain their health were provided with nutritionally enhanced food and drinks.
• Most people were happy with the food provided, one person said "'The food is good, you get plenty to eat, I'm not used to such big helpings, it's good solid food. Other people did comment that on occasion there was a lack of choice. One person said, "The food is quite nice. I get a choice of food. They don't usually ask me because they know what I like." Another person said "'You don't get a choice at dinner, you have what they give you. If I don't like it, they'll give me something else. Other than that, you have the meal they dish up."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Care assessments identified people's needs and identified people's changing needs. However, staff did not have full information on how best to meet these needs and people's choices in line with best practice guidance and people's preferences This meant staff did not have the guidance to ensure they provided appropriate and person-centred care. There is further detail about this in the safe and responsive sections of this report.

Adapting service, design, decoration to meet people's needs
• The decoration within the service had not been adapted to meet people's needs. There were few adaptations to support people living with sensory impairment or dementia to navigate around the home. There was no attempt to differentiate between areas of the home which would be helpful for visitors as well as for residents and there were few items or decor which may stimulate memories for people.

Ensuring consent to care and treatment in line with law and guidance
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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.
• Mental capacity assessments were completed, and related best interest decisions were decision specific. However, best interest decisions did not have recorded input from relevant health professionals to ensure less restrictive options were considered.

• Staff did not have a good understanding of the MCA. One staff member said, "Have heard of it, I don't know what it means." Another staff member said, "I know in my head but don't know how to explain it."

We recommend the provider consider current guidance regarding the mental capacity act and take action to update their practice accordingly

• Where restrictions had been placed on people's liberty to keep them safe, DoLS authorisation by the local authority had been applied for. None of the staff we spoke with were able to tell us which DoLS were authorised.
• We looked at peoples do not resuscitate orders (DNR) and treatment escalation plans (TEP). A DNR order, is a medical order written by a doctor. It instructs health care providers not to do cardiopulmonary resuscitation (CPR) if a patient's breathing stops or if the patient's heart stops beating. A TEP is an individual treatment plan which focuses on which treatments may or may not be most helpful for a person when they are in poor health. The TEP form can be used to document a decision in relation to CPR.
• The DNR's and TEPS had not been completed as required. Some did not have an appropriate mental capacity assessment completed. Other records did not show where the person concerned, or their family members had been consulted. The service had not checked these records to ensure people's rights were respected.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement.

This meant people were not always well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

• People told us they felt staff were caring and treated them well. One person said, "The staff are alright, they're a good laugh." Another person said "The staff are lovely. I don't need much help. I don't have any complaints that side [staff care] of it." A third person said "'The staff have been excellent, I give them first class."

• One person told us that they had not been offered food from their culture. The nominated individual told us the person could have asked for the food and it would have been provided. However, when planning the person's care, the provider should have considered and assessed if the person had any individual needs in relation to their culture.

• People's social and emotional needs were not met. Staff did not sit and talk with people for a meaningful length of time. For example, a person who could not leave their room did not have any recorded arranged activity, or companionship to ensure their needs met. The person's care plan stated they would receive regular companionship. However, daily records showed this did not take place.

• People were unnecessarily isolated from activities that they could have been involved in with support. One person who did not partake in group activities had a craft project which they wished to complete. The toolkit had been removed as it was deemed a risk to the person. However, no alternative toolkit or support had been sought or provided to enable the person to complete their project. The person said, "I've looked at it several times, but I can't do it [craft project] as they've taken the tools away."

• People took part in resident's meetings and were able to express their views collectively about topics such as group activities and food. However, there was not a record within care plans that demonstrated that people were regularly consulted about their individual choices for example in relation to person centred activities and meals.

Respecting and promoting people's privacy, dignity and independence

• Peoples' dignity and respect were not always protected. Information about people was not stored securely and kept confidential. We found people's personal notes and care records stored inappropriately in an unused unlocked bedroom; anyone within the home visiting or otherwise could access these records.

• We also observed advice and information for staff in people's bedrooms; this did not promote respect and dignity for people. For example, on the back of one person's bathroom door the Bristol stool scale was pictured for staff reference.

• All reasonable efforts had not been made to ensure that discussions about care treatment and support

only took place where they could not be overheard. The staff 'office' to update care plans and access records was situated in a lounge in the home. There was guidance for staff situated on and around the desk. Staff were also heard discussing people as room numbers and by name in the vicinity. This did not promote privacy or dignity for people.

• Staff told us how they promoted people's dignity whilst undertaking personal care. One staff member said they ensured peoples dignity and privacy by "Making sure doors closed, talk to people quietly if confidential. Keeping things private." One person said, "I shower and wash myself. Staff do help me, they're very good ."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences;
• Care plans were not fully personalised to enable staff to know people's individual needs and preferences. The service used an electronic care planning system. This initiated a care plan based on the information added by the service. Some of the care plans formulated by the electronic care planning tool had sections which were generic and not person centred to reflect people's individual needs.
• Care plans were not consistently person centred in relation to people's choices and preferences. For example, plans referred to people enjoying sweet or savoury food but with no reference to what foods that included. Other people had no likes or dislikes written into their plan or food preferences. Not all care plans included life histories and family information was brief.
• Care plans were regularly reviewed and updated however there was no record of how people or their relatives were involved. There was no record that people had input into their care and treatment.
End of life care and support
• There was no one receiving end of life care during the inspection. Care plans were not detailed in relation to people's preferences and choices in relation to end of life care. Records did not include preferences relating to protected characteristics, culture and spiritual needs.
Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• Person centred activities were not taking place. People who did not undertake the group activities lacked social stimulation. One person who did not take part in group activities said, "I haven't joined in very much, as I'm not interested in what goes on." Activities were not effectively monitored by the provider for their suitability or for their provision particularly for people who did not access group activities.
• People who required staff support to leave the service did not have regular access to the local community. One person said, "I tell the staff I would like to go out, but they don't always take me." Two people said they required to go out walking for their physical re-enablement however stated this did not take place as it should.

We found no evidence that people had been harmed. However, care plans were not person centred and people did not receive care that met their individual preferences. This was a breach of Regulation 9 (Person-centred care)) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to

follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
• People did not have information adapted in line with the AIS when they had a recognised difference. Care records for one person who had sight problems stated documents would be provided in large print. We asked the manager if a large print version had been provided for the person with sight problems, the manager checked and found that a large print version had not been provided.

Improving care quality in response to complaints or concerns
• People knew how to make a complaint and felt able to raise concerns if they were unhappy. They felt confident the manager would take action to address any concerns. People told us their complaints were resolved quickly. Where the service had received a complaint, this had been investigated and responded to appropriately.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate.

This meant there were widespread and significant shortfalls in service leadership .

At the last inspection we found that records were not completed effectively, and governance did not mitigate risks to people using the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection. At this inspection, we found the service had not undertaken steps to improve its governance to ensure that shortfalls were identified and rectified with a reasonable timescale.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements;
• The provider had failed to plan and take action to provide a high-quality service. This home was rated requires improvement following a focused inspection in December 2018. The provider sent us an action plan identifying improvement required. However, the shortfalls found at the last inspection have been repeated. The service has deteriorated, and the provider has been unable to sustain a good level of service.
• The provider has not used feedback to improve the quality of the service. The home has consistently been rated requires improvement at every ratings inspection over a period of four years and six inspections; four comprehensive and two focused inspections. Some of the regulatory breaches have been repeated.
• Action plans from audits where issues had been identified were not followed up with actions taken and timescales for completion. A general health and safety assessment report undertaken in January 2019 advised the provider of actions to be completed to ensure the service was safe. We asked for an update to the actions and found that the critical action in relation to fire risk had not been fully completed. There were also a number of other actions outstanding, including required works to the service lift. We were not assured that the provider had an efficient system in place to manage risks within the service environment .
• Person centred care planning had not been implemented effectively. People's risk assessments did not contain the necessary guidance to ensure staff would be able to mitigate risks effectively.
• Records relating to recruitment had not been checked robustly to ensure all necessary checks were undertaken . People's documents had not been stored in accordance with legal requirements.
We found no evidence that people had been harmed. However, the failure to ensure good governance to mitigate the risks relating to the health, safety and welfare of people amounted to a breach of Regulation 17 (Good governance) of the Care Quality Commission (Registration) Regulations 2009.
•The provider responded during and after the inspection to confirm that actions relating to checks of the environment and equipment such as the lift and mattresses were being undertaken.

Statutory notifications had not been made in line with current legislation to allow the Care Quality Commission to monitor the service. All services registered with the Commission must notify us about certain changes, events and incidents affecting their service or the people who use it. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled. We had not received statutory notifications in relation to people's DoL's and a safeguarding event.

We found no evidence that people had been harmed. However, the failure to notify as required was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 .

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The provider annually sought people's views by asking people and relatives for their views on various aspects of the home. We looked at the results from the latest survey undertaken and found the responses of the people surveyed were mainly positive.
• Where ideas had been raised at resident meetings there was not always a clear action plan or response to their feedback. For example, people had asked for an area where they could make their own drinks independently. There was no update to this action. The service told us they had provided areas where ready mixed drinks could be poured, however this did not enable people to make their own drinks independently.
• People were not engaged in creating strong links with the local community as they did not have the relevant support.
• There were no relatives meeting taking place to enable relatives to collectively share their thoughts and ideas and provide feedback to the provider.

Continuous learning and improving care; Working in partnership with others
• There was failure to ensure effective supervision and training had taken place as well as staff meetings, this gave little opportunity to provide feedback to staff and to share learning and good practice.
• The registered manager attended a local manager's network with other care professionals to improve information sharing and knowledge. These forums allowed for information sharing, professional updates and discussion around how to implement best practice guidance.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The provider understood their legal responsibility to respond to incidents with a duty of candour. However there had not been any incidents to report.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the commission of statutorily notifiable events.

The enforcement action we took:

We placed additional conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were not person centred and people did not receive care that met their individual preferences.

The enforcement action we took:

We placed additional conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured risks to people were mitigated. The provider had failed to ensure people's health needs were monitored effectively and that appropriate health referrals were made..

The enforcement action we took:

We placed additional conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to safeguard people by reporting alleged abuse, and abusive incidents.

The enforcement action we took:

We placed additional conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure the environment and service equipment were safe

The enforcement action we took:

We placed additional conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to to ensure good governance to mitigate the risks relating to the health, safety and welfare of people, and a good quality of service.

The enforcement action we took:

We placed additional conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure recruitment was safe and robust.

The enforcement action we took:

We placed additional conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staff received necessary training and opportunities for supervision.

The enforcement action we took:

We placed additional conditions on the provider's registration.