Mr & Mrs BN Patel

Cedars Residential Care Home

Inspection report

Sudbury Road
Halstead
CO9 2BB
Tel: 01787 472418

Date of inspection visit: 25 and 26 June 2015
Date of publication: 11/09/2015

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

Overall summary

The inspection took place on 25 June 2015 and was unannounced.

The service provides accommodation for up to 63 people, some of whom are living with dementia. At the time of our inspection 56 people were resident. The service is split into two buildings which operate quite separately.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Medicines were not managed safely. Some were not stored correctly which could have compromised their effectiveness and safety. Records were not always

Summary of findings

completed and some medicines were not given according to the prescriber's instructions. Medication audits did not identify the issues we found relating to unsafe administration of medicines.

Staff were trained in safeguarding people from abuse. The management of the service had not always referred incidents appropriately to the local authority safeguarding team.

Risks were assessed but these assessments did not always contain sufficient detail to guide staff and ensure risks were minimised. Steps taken to address an identified risk for one person, increased the risk for others. We found that risks related to fire and the environment were not well managed. The service was not proactive with regard to the prevention of pressure ulcers for people with limited or no mobility.

People told us they felt there were sufficient staff on duty but we saw occasions when there were not always enough staff to meet people's needs promptly. Staff received the training they needed to carry out their roles.

We saw that although staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) the service did not always act accordance with them. The MCA ensures that people's capacity to consent to care and treatment is assessed. If people do not have the capacity to consent for themselves the appropriate professionals and relatives or legal representatives should be involved to ensure that decisions are taken in people's best interests according to a structured process. DoLS ensure that people are not unlawfully deprived of their liberty and where restrictions are required to protect people and keep them safe, this is done in line with legislation. We found that people's liberty was restricted by the use of locked doors and keypads.

People who used the service praised the food and people were referred to dieticians and other healthcare professionals when they needed them..

Staff were caring and committed and we saw that people were treated respectfully and their dignity was maintained. Staff demonstrated skill and patience with people who were anxious or distressed.

Some people did not feel they had been sufficiently involved in planning and reviewing their care.

People were not supported to follow a wide range of hobbies and interests. People living with dementia and those unable to go out independently lacked stimulation.

Formal and informal complaints were managed well and to people's satisfaction.

Staff understood their roles and most felt they were well supported by the management team. Some people found the management style was not always supportive of the staff.

Systems designed to assess and monitor the quality of the service were in place but were not always effective.

We found breaches of regulations which relate to the management of medicines, the management of risk and the deprivation of people's liberty, staffing and safeguarding people from abuse. You can see what action we have told the provider to take at the back of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines were not managed safely.

Risks were assessed but assessments were not detailed and did not always contain the most up to date information.

Systems were not in place to protect people from developing pressure ulcers.

We were concerned that some aspects of the building were not safe and some steps taken by the management to reduce a risk had put people at greater risk.

There were not always enough staff to meet people's needs.

Is the service effective?

Requires improvement

The service was not always effective.

The requirements of the law with regard to the MCA and DoLS had not been followed in all cases.

Staff received the training they needed and were positive about the quality of this training.

People were very positive about the food and they were supported to access healthcare professionals when they needed to.

Is the service caring?

Requires improvement

The service was not always caring.

Staff were caring and treated people with respect. Feedback from people who used the service, relatives and professionals was very positive about the kindness and patience of the staff.

We observed good relationships between the staff and the people they were supporting and caring for.

People, or their relatives, were not always involved in making decisions about their care.

Is the service responsive?

Requires improvement

The service was not responsive.

People, and their relatives, were not always involved in assessing and planning their care. Care plans did not always contain sufficient detail to guide staff.

There was a mixed picture regarding people following their own interests and hobbies. Some people were able to access the local community independently and were positive about the programme the service offered. Others were unhappy and felt there was nothing provided which suited them.

Summary of findings

Is the service well-led?

The service was not always well led.

People and their relatives did not feel they were actively involved in developing the service.

Staff understood their roles and were well supported by the management team, although some described the management style as divisive.

Audits designed to assess and monitor the quality of the service did not identify the issues we found.

Requires improvement

Cedars Residential 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.

The inspection took place on 25 and 26 June 2015. Both inspections were unannounced.

The inspection team on 25 June consisted of two inspectors, a pharmacist inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert had experience of services for older people and of dementia care. On 26 June two inspectors carried out an early morning inspection to speak to the night staff and observe morning routines.

Before we carried out our inspection we reviewed the information we held about the service. This included any statutory notifications that had been sent to us. A notification is information about important events which the service is required to send us by law.

We spoke with eighteen people who used the service, four relatives, one visiting professional, a nurse practitioner, seventeen care staff, the deputy manager, the administrator and the registered manager.

We reviewed seven care plans, ten medication records, five staff recruitment files, staffing rotas and records relating to the maintenance of the service and its equipment.

We observed staff providing care and support and 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 communicate with us easily.

Inadequate

Is the service safe?

Our findings

There were appropriate arrangements in place for the ordering and disposal of medicines and we found that staff received the appropriate training. Competency to administer medicines was checked as part of a monitoring process.

We had concerns about other areas related to the administration of medicines to people. Care plans did not always contain information about how people liked to take their medicines. Three of the plans we looked at contained no information about this.

We observed medicines being given to some people at lunch time. We saw that this was done with regard to people's personal choice. However three people also told us that staff did not do this all the time. One person said, "I tell you what I don't like. I don't know what medication I am having. They just dollop it in my mouth. I like to know what's in my mouth".

Medicines were stored securely but were not stored safely for the protection of people who used the service. Medicines were stored above the temperature which is deemed, by the manufacturer, to be safe. Daily temperature logs were kept but no action had been taken when the temperature had been recorded as being too high to ensure medicines remained safe and effective.

The cupboard used to store controlled drugs in one area was not of an appropriate standard. Controlled drugs are medicines that the law requires are stored in a special cupboard and their use recorded in a special register. We brought this to the attention of the manager and this was resolved immediately.

Seven records contained gaps where staff should have signed to confirm a medicine had been administered. Records for topical medicines which people kept in their bedrooms were seen to be incomplete in all the records we looked at. We therefore could not be assured that people had received their medicines as prescribed. Medication audits, which were carried out weekly and monthly, had failed to identify the issues we found.

We noted that some people were not given their medicines in line with the prescriber's instructions. For example, a medicine prescribed to be used only when required was recorded as being given regularly each morning. Staff told us that this had been agreed with the person's GP but we could not find a record to support this. We also found that where people received their medicine in the form of a skin patch, the site of application was not recorded. This risked damaging the people's skin. Staff we spoke with confirmed that no record was made, and that they were not aware of this special instruction. We also found that one person's medicines were given disguised in food. This had been authorised up by the GP but had not been reviewed since April 2014.

This was in breach of regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that risks, such as those related to moving and handling and a person's risk of falling, had been assessed and actions put in place to reduce these risks as much as possible. However, we were concerned that these risk assessments were not always detailed enough and had not always been appropriately updated. For example, we saw that one person, who had sustained 13 falls in the last year, had a record of a fall near the bottom of the main stairs. This fall had resulted in a deep wound to the person's head which required stitching. The falls risk assessment had been reviewed a few days after this incident but did not reflect the potential additional risk of the stairs. We saw that the service had thought about this particular risk and had placed a chain across the bottom of the stairs. We were concerned that this would prove a trip hazard to other people and was also not an effective way of reducing the possible risk of a fall on the stairs for the person concerned. The chain was removed during our inspection and the service has since put other measures in place to safeguard this person.

We noted that some people, who might be at risk of developing a pressure ulcer, were in one position in the same chair for several hours. Although staff did support others to have a lie down on their bed after lunch we also observed that some people had very little change of position. People were provided with appropriate pressure relieving cushions and mattresses to reduce the risk of developing a pressure area. We noted that one mattress was set incorrectly to a weight at least 15 stone heavier than the person actually was. We brought this to the attention of staff. We also noted that charts confirming that people had been given a change of position when in bed

Inadequate

Is the service safe?

had not been completed – in some cases for many days. This meant we could not be assured that people were receiving the correct pressure care and were at risk of developing pressure ulcers.

We observed that a garden hose was blocking a ramped pathway to the garden about one foot from the ground. We asked the maintenance man to ensure this did not present a trip hazard to people. We also noted a bench in the garden which was not securely sited and would have easily tipped backwards had somebody sat on it. Again this was put right immediately but we were not assured that the service assessed and prioritised people's safety as they moved about the service.

We were also concerned that we saw several fire doors propped open during our visit, one by a chair which made it difficult for people to pass. A staff member confirmed to us that fire doors are often propped open. We raised concerns about the fire exit at the main door. As well as the presence of a chain across the bottom of the stairs which were in front of the main fire exit, we noted that the inner doors had a bolt high up which needed to be undone. In the event of a fire this would increase the time it would take to evacuate people as quickly as possible. The provider has confirmed to us that this bolt has now been removed. We referred the matter to the fire officer who has carried out an inspection visit. Since our inspection the chain has been replaced with a stairgate which the fire officer found acceptable.

Each person had a personal emergency evacuation plan (PEEP) which documented how they should be evacuated in the event of a fire. Information in these PEEPs was not always as detailed as it could be and we were not assured that all staff would know exactly what help people would need in the event of a fire, particularly at night.

This demonstrated a breach of regulation 12 (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living in the service. One person told us, "The nurses are so attentive. They make sure you are alright". We found that systems were in place to reduce the risk of abuse and to ensure that staff knew how to spot the signs of abuse and take appropriate action Staff were able to tell us what they would do if they suspected or witnessed abuse and knew how to report issues both within the company and to external agencies.

Staff had received training in safeguarding people from abuse and were aware of the service's whistle blowing policy. They told us they would know what to do if they had concerns about other members of staff. Our records showed that the service had reported no safeguarding concerns since our last inspection. We were aware of some incidents, such as unexplained bruising and an unexplained fall, which it would have been appropriate to refer to the local authority safeguarding team for investigation and we raised this issue with the manager.

This demonstrated a breach of regulation 13 (2) and (3) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

We received a mixed picture about the staffing levels at the service. We saw that the manager had assessed the numbers of staff required to meet people's needs and records showed that the service operated according to these levels and had a stable staff team. Some people who used the service were keen to tell us how quick the staff were to offer care and support. One person said, "They come quite quickly. When I press my button they bring me down [for breakfast]". Another said, "At times there were shortages of staff but most of the time staff were available". Other people and relatives praised staff but also said things like, "Very often you have to wait to get hold of the staff" and ,"They come if they are not too busy". One person said, "Staff run about. Residents call out and staff are too busy. There's not enough of them – no way".

Our observations on the day were that there were certainly times when staff were not able to meet people's needs quickly and ensure their safety. We observed people crying out for several minutes to be helped to go to the toilet or to get a cup of tea. On one occasion we saw that a fairly new member of staff was left for a period of 10 minutes on their own with 15 people, one of whom was very distressed and needed the toilet, another who was screaming for a cup of tea and another who was clearly distressed. Other staff on this unit were supporting other people in their rooms but the effect of this staffing level was that the experience for some people was very poor for that period of time.

This demonstrated a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

Staffing levels at night and first thing in the morning were appropriate and enabled people to get up when they wanted. Staff on the night shift told us that they felt staffing levels were acceptable and were very positive about the care and support they were able to provide.

Staff employed at the service had been through a thorough recruitment process before they started work. Permanent and agency staff had checks in place from the Disclosure and Barring Service to establish if they had any criminal record which would exclude them from working in this setting. All the required checks had taken place before staff were employed to work at the service.

Requires improvement

Is the service effective?

Our findings

The registered manager told us that they had applied for 11 DoLS authorisations. One had been agreed and the others were being considered by the local authority. When speaking with staff we established that although all of the care staff had received training in the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) they were not able to demonstrate an understanding of DoLS requirements. We found that throughout the home keypads and locks were fitted to all outside doors. Although people told us they were free to leave the property if they wished and only had to ask staff to let them out, staff did not demonstrate to us how they ensured people's freedom was not unlawfully restricted. One person told us that they would like to go out but they were not able to do so. They said they went out once a month with staff. Other people told us they regularly went out to fetch the papers or to go visiting but these people were not permitted to have the code for the keypad and had to ask staff to let them out each time.

We saw that even access to the garden was restricted and when we asked staff if people have free access to the garden they told us, "Not really. Sometimes they try and get out. [Named person] definitely would". The service was not able to show us how they kept people safe within the requirements of the DoLS.

This was in breach of regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed throughout the day that people's consent was routinely asked for before care and treatment was provided. We received comments such as, "If I said no to anything the staff would not make me" and, The staff always ask me if they can help before they do anything".

However, whilst we did see very good interactions between staff and the people they were supporting, we also noted one occasion where two staff came into the lounge and began to move a person using the hoist. The person became anxious and asked the staff what they were doing. The staff did not respond to them and they became increasingly distressed. At this point a member of staff explained that they were taking the person for a bath. This incident represented a poor experience for the person concerned. People also expressed to us that there were other times when they were not asked for their consent with regard to taking medicines. One person said, "Staff don't tell me what it's for". We noted that care plans contained an assessment of people's capacity to consent to day to day decisions.

People who used the service told us they were happy with the way the staff team supported and cared for them. People told us that the staff were well trained and they had confidence in their skills and abilities. One person said, "They've got an air of confidence". Another person said, "They know what they are doing". A relative explained to us, "My relative is well cared for and this means I can go away for a short holiday at times, knowing they are safe".

Staff undertook an induction when they joined the service and carried out training which covered core skills such as moving and handling people, infection control, food safety and medication administration. Staff were able to shadow more experienced members of staff for a number of shifts to help them gain both competence and confidence before working as part of the permanent staff team.

Staff were positive about the training they received. One member of staff told us, "The training we get is good and we always seem to be doing updates". Training records confirmed that staff were provided with the training they needed to carry out their roles. Staff told us they received regular supervision and appraisal and records supplied confirmed this.

Five staff were not at all clear about who had a Do Not Attempt Resuscitation order (DNAR) in place which meant that people's wishes regarding the end of their life might not be respected.

People who use the service were very positive about the food and felt the chef made sure people were happy with the meals. One person told us, "Excellent. Compliments to the chef. It's very good food and it's properly cooked and served". Another person said, "The food is lovely – it's marvellous!". There was a choice of food each day and menus were changed regularly and took account of people's choices and preferences. A relative of a person who used the service said, "My relative won't eat. The staff do everything they can to help. [My relative] has seen a dietician and now has fortified drinks".

People who needed help and support to eat their meal were mostly given this in a sensitive manner with the staff working at the person's pace and not rushing them.

Requires improvement

Is the service effective?

However we saw two occasions where staff were not working so sensitively. One member of staff was seen to stand over a person while they fed them and another fed two people at once.

We observed a lunchtime service on both the units and saw that these were quite task driven. Many people ate in the lounges as there were not enough tables for everyone in the dining rooms. Undoubtedly some people chose to eat in the lounge but we saw that the experience was not a pleasant and sociable occasion. We saw that people waited to be supported to eat their dinner and meals in the lounge and in the small dining room, were taken in silence. Nobody asked if people would like some music or the television on. There was little chatter as staff were very busy supporting people to try and eat their meals while they were hot.

We saw that care plans contained information about people's dietary likes and dislikes and where people had been assessed as being at risk of not eating or drinking enough, systems had been put in place to monitor their diet and weight and refer them, if necessary, to a dietician. Some food charts we saw had not been fully completed which meant we could not be assured that people's eating and drinking was being sufficiently monitored.

Records showed that people had access to a variety of healthcare services including GPs, district nurses, psychiatrists, opticians, dentists and chiropodists. People told us staff responded quickly to their healthcare needs. One person showed us their new glasses. Another person told us they had been to a recent hospital appointment and one of the staff remained with them when they saw the doctor to discuss their treatment. They found this helpful and comforting.

Requires improvement

Is the service caring?

Our findings

People who use the service, and their relatives, were very happy with the way staff supported them. One person said, "They sort everything for me. I don't have to worry. The staff seem to care about us and are kind". Another person told us they often get confused and start getting dressed in the middle of the night. They said, "I woke up last night at 3am thinking I should be at work. I was just getting dressed when, imagine my surprise, to find [staff member] in my doorway. [They] told me I did not have to be at work and we had a laugh. [They] made me feel so much better and I went back to sleep". This demonstrated a close and trusting relationship had built up between the member of staff and the person they were supporting so sensitively.

Another person who used the service told us that they like to get up early and staff made them a morning cup of coffee. They said, "Tap on the door. The door opens and a hand comes round with my coffee!". All the relatives we spoke with were very happy with the way staff cared for their relatives and commented on the patience and kindness of the staff. One relative said, "They are very caring. I have never had any complaint. They get to know people's individual needs". Another said, "The staff are polite, kind and respectful and treat everyone in a friendly way".

We observed that people were treated with warmth and kindness and staff were quick to reassure people if they were confused or upset. We saw that one person became very anxious and a staff member went straight to them, got down to their eye level, took their hand and spoke gently to them until they visibly calmed. A visiting professional and relatives also commented favourably on the way staff provide comfort to people when they are upset and distressed. Information about how to support people when they were anxious or distressed was included in the care plans.

Care plans included information about people's life histories, including their family background, previous working life and friends who are important to them. Plans included people's choices and preferences.

We received a mixed picture as to people's involvement in making decisions about their care. We saw that most care plans, which were reviewed monthly, had been shared with the person they concerned and these plans had been signed by them or their relatives if more appropriate. A relative told us, "Every month I have to read it and sign it". Other people and relatives told us that they had never had the opportunity to be involved in reviewing their care plan. For example one relative said, "I have not been asked to give my opinion about the care my relative receives and have not seen the care records held about them". Another relative stated, "I have not taken part in any reviews- and I visit regularly".

Although some people felt they had not been sufficiently involved in a formal way in reviewing their care, most people felt that they were able to discuss their care, or that of their relative, with the staff, the deputy manager or the manager if they had a concern. One relative said, "Staff are always willing to have a quick word".

Advocacy services were not routinely used by people at the service and we saw no information was available for people should they wish to consider the services of an advocate for themselves or their relative. We did not see a strong commitment by the service to provide information in formats which would be accessible to people. For example menus did not include pictures or photographs and food was plated up and served without further explanation. People living with dementia were not reminded of the food choice they had made earlier so some people may have been confused about what they were about to eat..

People's dignity was maintained when staff were offering to provide personal care. Staff offered this kind of support discretely and people told us that they were happy with the sensitive way staff treated them. Staff had received training in dignity and respect. One member of staff explained to us, "We get to know people really well and even those who cannot tell us their views we recognise when they disagree with us by their facial expression or the shaking of their head. We respect their views".

Requires improvement

Is the service responsive?

Our findings

We saw that people's needs were assessed before they moved into the service. People told us that they had been visited by the manager of the service and once their care and support needs had been assessed a care plan had been drawn up.

People who used the service, or their relatives, had mostly been involved in developing their care plans and plans reflected how people wished to receive their care and support. One person told us that they liked to get up earlier than they used to and we saw that their care plan had been changed to reflect that they now wished to get up at 6.30 instead of 8.00 or 9.00am. Care plans did not contain information about whether people were happy to receive care, particularly personal care, from a staff member of a particular gender.

We saw that plans were reviewed monthly but were not always updated promptly when care needs changed. For example we saw that one person had been fitted with an in-dwelling catheter. The care plan, following this change, merely stated ' needs assistance with in-dwelling catheter'. There was no additional information guiding staff as to what the nature of this assistance was. At night the plan had been changed to state 'give full catheter care' but this care was not explained. In the same plan it was stated in the section regarding pressure care 'move [the person] to relieve pressure'. This is not enough information to ensure that the person would be adequately protected from developing a pressure ulcer.

Staff told us that information is handed over verbally. One staff member told us, "We learn from each other what works and what does not work". We observed a handover between shifts and saw that comprehensive information was passed from one shift to another. Each person was discussed and any relevant points, such as changes in people's mood or routines, were handed over.

There was a mixed picture with regard to people following their own interests and hobbies. Those more able service users were able to access social opportunities outside the service quite easily and many did. Those people who were more dependent on staff were not happy with the opportunities for social interaction and occupation given to them. One relative said, "They do have some activities here for people to take part in but not the ones my relative is interested in. I think they are mostly aimed at people who are more able than my relative".

We received comments such as, "Nothing to do here except look at each other. There are some things arranged, but not things I like to do. Nobody has asked me what I like to do" and "I would like to do some gardening but it never seems possible. They just sit me in the lounge and that drives me mad". Another person said, "I don't go out. I've got the telly I suppose and sometimes I read a book. I used to do the garden but I can't do it here".

We saw that occasional outings to a tea dance were arranged and these were popular. The service had an activity co-ordinator but, although she was working on the day of our inspection, we were only able to observe them doing a jigsaw with one person. People were seen to sit about all day with very little stimulation. Sometimes the television was on but we noted that people were not consulted about this or asked which channel they wanted. Some people were seen to entertain themselves with knitting or jigsaws but many people appeared to be sitting and waiting for the next cup of tea or meal.

Resident meetings were not held regularly and meetings for relatives to attend were not held. One relative commented to us, "We do feel listened to but there are no resident/relative meetings for us to attend". The impression from most people we spoke to, and relatives, was that there were no formal opportunities for people to discuss the service even though we saw records which showed some meetings had taken place. We concluded that the service was not proactive about these meetings and did not use any other format, such as surveys, to get feedback from the people who use the service or their relatives.

The service had a complaints procedure and people, and their relatives were aware of it. The service had received four complaints since our last inspection and we saw that these had been responded to promptly in writing and had been resolved to people's satisfaction. Where people had raised informal concerns they told us that staff responded quickly to put things right. One relative told us, "If we need to discuss anything with the deputy manager they are very helpful".

Requires improvement

Is the service well-led?

Our findings

Most people who used the service, their relatives, and the staff said they found the management team approachable. One person who used the service said, "If I had a complaint I would go to the office". A member of staff told us that they felt that morale in the staff team was good and that the providers were available in the service most days. Records confirmed that this was the case. A nurse practitioner told us, "It is a home which is on the whole well run. The owner [and registered manager] is very aware of what goes on. Mention anyone's name and she knows".

We also had some staff and relatives tell us that they felt that the manager had a style of management which could be seen as divisive. People told us that they felt that, although they had no worries about the way the manager delivered the service to the people who lived there, sometimes they felt staff were not as well supported by the management as they should be. We spoke to the manager about this and they felt that their passion to do a good job for the residents may have been misinterpreted at times. They took on board the feedback we gave them.

People told us they didn't feel they had sufficient opportunities to influence the way the service was run. Resident meetings were not frequent and, although they took place, none of the people we spoke with told us that they had attended one. Similarly relatives felt that, although very happy with the service, they also had limited opportunities to provide feedback. Staff surveys were not conducted but staff told us they felt there were opportunities for them to raise issues and give feedback at their supervision sessions and staff meetings. Staff told us that they felt the service had an open culture. However we could see little evidence to demonstrate this and people could give us no examples of where suggestions from people who used the service, their relatives or staff had been taken up and led to a change in the way the service was delivered.

Systems were in place to monitor the training and supervision of staff. A training matrix identified if staff were overdue for any refresher training and we saw that there was an on-going training programme in place. An audit system was designed to assess and monitor the quality of the service provided. The deputy manager explained to us that monthly audits were carried out on care plans, falls, pressure care, medication and infection control. Weekly and daily medication audits were in place related to the administration of medicines. Although these audits were in place they were not always robust as the issues we had identified related to medication, falls, pressure care and failure to complete care charts had not been addressed.

People's care records were stored in the staff room in an unlocked cabinet which meant people could not be fully assured that their personal information remained confidential. Care records were stored as paper records and were well organised although we did note in some records that older information had not always been archived which could have been confusing for staff. As noted elsewhere in this report records related to the administration of medicines and food and fluid charts and repositioning charts were not always completed. Staff records were well organised and complete.

The registered manager understood their responsibility and had sent all of the statutory notifications that were required to be submitted to us for any incidents or changes that affected the service. We identified some incidents which it would have been appropriate for the manager to refer to the local authority safeguarding team.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment The service failed to adequately assess the risks to the health and safety of service users and to do all that is reasonably practicable to mitigate any such risks. Regulation 12 (2) (a)(b) The service did not have suitable arrangements in place for proper and safe management of medicines. Medicines were not stored safely for the protection of people who used the service. Medicines were not given to people in line with the prescriber's instructions. Regulation 12 (2) (g).

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 Systems and processes did not operate effectively to prevent abuse of service users or to investigate, immediately upon becoming aware of, any allegation or evidence of abuse. Regulation 13 (2) and (3) Service users were deprived of their liberty without lawful authority. Regulation 13 (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed. Regulation 18 (1)