Alphacare Holdings Limited

The Cedars Nursing Home

Inspection report

Northlands, Landford,
Salisbury
Wiltshire
SP5 2EJ
Tel: 01794 399040
Website: www.brighterkind.com

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Ratings

Overall rating for this service	Inadequate
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?	Inadequate

Overall summary

The Cedars Nursing Home is a care home which provides accommodation, nursing and personal care for up to 62 older people. At the time of our inspection 52 people were resident at the home.

This inspection took place on 8 June 2015 and was unannounced. We returned on 10 June 2015 to complete the inspection.

At the last inspection in July and August 2014 we identified that the service was not meeting Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because there were not enough staff to meet people's needs. The previous registered manager sent us an action plan and said they were taking action to address the issues, which would be completed by the end of December 2014. During this inspection we found that staffing levels were still not being managed effectively and there were not always enough staff deployed to provide safe care.

The home did not take appropriate measures to keep people safe. Medicines were not always managed safely and the infection control procedures were not always

Summary of findings

followed. Risk assessments had been completed for some people. However, they were not always kept up to date and did not always set out how staff should manage the risks that had been identified.

Staff did not understand their responsibilities under the Mental Capacity Act 2005 and the action they needed to take if people did not have capacity to consent to their care.

People told us staff were kind and did their best, but were hampered by there not being enough of them. We observed staff being kind to people, but also saw examples where staff were communicating in ways that did not demonstrate respect for people.

Care plans were not always fully completed or kept up to date to reflect people's needs. This meant staff were not given clear information about people's specific needs or the action they should take to meet them.

The home was not well managed. Shortfalls were not identified and effective action was not taken in response to concerns about the service.

We found 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 this report.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.
- Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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?
The service was not safe.

There were not enough staff deployed to provide safe care. Medicines were not always managed safely and the infection control procedures were not always followed.

Risk assessments had been completed for some people. However, they were not always kept up to date and did not always set out how staff should manage the risks that had been identified.

Inadequate

Is the service effective?
The service was not always effective.

Staff did not understand their responsibilities under the Mental Capacity Act 2005 and the action they needed to take if people did not have capacity to consent to their care.

Some people said they enjoyed the food, however, we saw that support for people who needed help to eat was not effective due to the number of staff available.

People were able to see relevant health care professionals when needed.

Requires improvement

Is the service caring?
The service was not always caring.

People appreciated the friendliness of staff and reported they had a good relationship with them.

Staff were kind to people most of the time. However, we also observed some interactions where staff did not demonstrate respect for people in the language they used or in their response to people's requests for assistance.

Requires improvement

Is the service responsive?
The service was not always responsive.

Care plans were not always fully completed or kept up to date to reflect people's needs. Staff were not always given clear information about people's specific needs or the action they should take to meet them.

People with dementia were not given enough social stimulation. Activities that were planned did not always take place and there were not enough staff to provide one to one time with people.

Requires improvement

Is the service well-led?
The service was not well-led.

Inadequate

Summary of findings

There was no registered manager in post and shortfalls in the service being provided were not identified or action taken to resolve the problems.

The management systems did not identify trends emerging from feedback the service had received or ensure that action was taken to ensure the service operated within the law.

The Cedars Nursing 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 to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 8 June 2015 and was unannounced. We returned on 10 June 2015 to complete the inspection.

The inspection was completed by one inspector and a specialist advisor in the nursing care of people with dementia. We reviewed the Provider Information Record (PIR) and previous inspection reports before the inspection.

The PIR was information given to us by the provider. This enabled us to ensure we were addressing potential areas of concern. We also looked at the notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us. We received feedback from a nurse practitioner who had contact with the service and spoke with a visiting GP during the inspection.

During the visit we spoke with seven people who use the service, four relatives and eight staff, including nurses, care assistants, housekeeping and maintenance staff. We spoke with the regional manager and regional support manager who were providing management cover for the service. We spent time observing the way staff interacted with people who use the service and looked at the records relating to care and decision making for three people. We also looked at records about the management of the service.

Inadequate

Is the service safe?

Our findings

At the last inspection in July and August 2014 we identified that the service was not meeting Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because there were not enough staff to meet people's needs. The previous registered manager sent us an action plan and said they were taking action to address the issues, which would be completed by the end of December 2014. During this inspection we found that staffing levels were still not being managed effectively and there were not always enough staff deployed to provide safe care.

All of the people we spoke with who were able to express a view said there were not always enough staff available to provide the care they needed when they needed it. People gave examples of staff taking a long time to answer call bells and not being given support to go outside to have a cigarette. One person described the provision of staff at weekends as "Desperately skeletal, extremely poorly staffed at weekends". People's relatives we spoke with were also concerned about the staffing levels in the home. One relative said there had been several occasions in the previous month when they felt the staffing levels were unacceptable and not sufficient to provide the care that their relative needed.

All of the care and nursing staff we spoke with raised concerns about the staffing levels in the home. A care assistant told us there had only been seven care assistants on duty at times over the previous weekend, instead of nine. The care assistant gave examples of care tasks they had been unable to complete. The examples included not repositioning people as often as they needed to minimise the risk of pressure ulceration; not being able to provide personal care support to people promptly when they needed assistance to wash and change continence pads; and, not having time to support people to drink fluids. Other care staff said they could not always support people to clean their teeth in the mornings because they were short staffed and people were left in bed for a long time. Comments included, "You can give people care when you're free, but they have to wait", "I don't feel people get the care they should. You have to rush people. We answer the call bells but have to tell people to wait", and "When we are short staffed residents don't get the care they need".

We received feedback from the nurse practitioner who visited the service that staffing levels were not always reliable, commenting that they found it difficult to contact nurses by telephone.

We discussed these concerns with the regional support manager, who told us the staffing levels were based on an assessment of people's dependency, which was completed monthly. We saw the last dependency assessment had been completed on 7 May 2015 and stated there should be nine care assistants and two nurses on duty between 7am and 7pm, with four care assistants and two nurses between 7pm and 7am. The regional support manager told us they were confident they met their minimum staffing requirement and tried to provide more than their minimum staffing levels. On looking at the staff rotas we saw that on the previous Saturday there had only been seven care assistants, as had been reported by the staff we spoke with. The regional support manager said in addition to the care assistants, there was an activities assistant on duty between 9am and 6pm, who was a qualified carer, but acknowledged this still left the home with less staff on duty that they had assessed was needed to provide safe care.

We looked at the home's rotas for the period between 27/4/15 and 24/5/15. During this period we saw that there were seven occasions when that staffing levels in the home fell below what the service had assessed as necessary to meet people's needs.

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

The home did not have safe systems for identifying and managing risks to people who use the service. One person was described by staff as being "very aggressive" and notes of incidents referred to the person "punching and kicking" at staff. We looked at the person's care records on the first day of the inspection and they did not have any information about the possible causes of this distress or the support staff should provide. There were pre-printed care plan forms in the file for psychological / emotional, communication and behaviour needs, but these had not been completed and were left blank. The person had lived in the home for approximately two weeks at the time of the inspection and the daily care records contained details of

four occasions when they had been distressed and hit out at staff. One incident record stated three care staff were needed to provide support, but it was not clear what the staff were doing to meet the person's needs.

The same person had an initial assessment before moving into the home identifying needs in relation to their mobility and a risk of falling. There were pre-printed care plan forms in their file covering mobility and a falls risk assessment, but these had not been completed and were left blank. During the inspection we observed this person struggling to get out their armchair and very unsteady on their feet. We intervened as we felt the person was at risk of falling and there were no staff available in the lounge at the time. We asked for staff assistance and two staff supported the person to walk to a different part of the home.

Another person had a record of unintended weight loss, with no recorded action to manage the risks. The person had lost 1.4kg in February 2015 and a further 1.3kg in March 2015. There were no further entries in the person's care records after March 2015 and there was no plan in place to manage the risk of malnutrition. We discussed this issue with the regional support manager, who found another weight record for this person. The additional weight record showed that the person lost 4.4kg in April 2015 and gained 2.8kg in May 2015. There was no record of any action in relation to the unintended weight loss and the risk of malnutrition. The regional support manager told us she did not think the recorded weight loss was correct, but could not say what the weight loss was or what action had been taken in response.

A third person was identified as being at high risk of developing pressure ulcers and of falling. Risk assessments covering these areas had been completed in February 2015 and stated they should be reviewed each month. No reviews of these assessments had been completed to assess whether the control measures in place to minimise the identified risks were effective and keeping the person safe.

We found that risk assessments for people who needed bed rails stated the rails were safe, when we found they did not meet the guidance for a safe height between the mattress and the top of the rail. When we discussed this with the staff responsible for their completion, we found they did not understand the guidance. This increased the risk that people may fall over the rail and be injured.

The fire evacuation process for the building was not understood by all staff. 75% of staff in the dementia unit on the second day of the inspection were unaware of the location of fire evacuation equipment, including an evacuation mat. The nurse in charge of the shift could not find the fire evacuation mat initially, and later found it in the locked treatment room, obscured by other items stored in the room. One care assistant told us they thought the evacuation mat was located in the shower room.

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

Safe practices in relation to the storage and administration of medicines were not always followed. The medicines fridge was not checked each day and a maximum and minimum thermometer was not used. On the second day of the inspection the medicines fridge alarm was activated for two and a half hours as the temperature had exceeded the maximum level. Action was not taken until we highlighted the alarm to a member of staff. When opened, we saw the medicines fridge contained out of date yoghurt in addition to medicines. The nurse removed the medicines to another medicines fridge, but did not seek advice from their pharmacist as to whether this temperature increase would have had any effect on the medicines.

For people who were prescribed medicated creams we found gaps in records that they had been administered. For example records of administration of a medicated cream had been completed once in the previous 10 days for one person and three times in the previous 10 days for another person. Two other people were prescribed emollient creams to soften their skin, that were due to be applied twice a day. There was no record that it had been administered on 19 occasions for one person and 16 occasions for the other person during May 2015. The care plans for another person's medicated cream did not specify how frequently it should be applied or where it should be applied. We spoke with two care assistants about where this medicated cream should be applied and they gave different answers.

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

We found that the medication administration records had been completed correctly for other medicines people were

prescribed. There was a record of medicines brought into the home and medicines destroyed because they had been spoilt. There were guidelines in place when people were prescribed a variable dose of medicines and when they had been prescribed medicines to be administered 'as required'.

People were not protected by the home's infection control measures. One of the sluice rooms was cluttered with walking frames and commodes, including dirty commode inserts. This was obstructing safe access to the sluice. Staff we spoke with could not find the goggles to provide protection when emptying urine and faeces into the sluice. Clean mattresses, air mattress pumps and water jugs were stored in the same area as dirty commode inserts. There was a cupboard in the sluice room which contained cleaning materials, dirty cloths and a pack of denture cleaning tablets. We found a plastic cup of yellow liquid next to a basket of urine testing kits. Staff were not able to explain what it contained or how long it had been there. There was a yellow bin of clinical waste which was overflowing and the lid would not close.

We saw that a wet room had not been cleaned after people had been supported to use it. We found a shower chair with brown staining on the seat and dried talcum powder on the back rest, indicating it had not been cleaned after use. The wheels of the shower chair were dirty. There were no hand drying facilities in the room. The drain cover on the floor was missing and flooring was lifting round the edge of the drain.

A commode in a person's room was visibly dirty, including the wheels. Talcum powder could be seen on the commode seat, indicating it had not been cleaned after personal care had been delivered.

People did not have individual hoist slings. A nurse we spoke with was aware this was contrary to good infection control practices and stated that they had asked for more slings. We observed care assistants hoisting people with a communal sling, referred to by staff as a 'general use sling'. A care assistant also told us they would like to have more hoist slings that were specific to the person. They told us they had to use slings from other people and they were concerned about the infection control risk.

We found that padded bed rail protectors were soiled and sticky to touch. When this was shown to a member of staff they acknowledged that it was dirty, but explained that as they were short staffed it was not a priority. The member of staff told us, "Something has to give".

The regional support manager had completed a monthly return to the regional manager, identifying there was no infection control lead in the home. The report stated the infection control lead would be the new deputy manager when they were recruited. At the time of the inspection the new deputy manager had not started in post and there was still no infection control lead in the home.

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

Effective recruitment procedures ensured people were supported by staff with the appropriate experience and character. This included completing Disclosure and Barring Service (DBS) checks and contacting previous employers about the applicant's past performance and behaviour. A DBS check allows employers to check whether the applicant has any convictions that may prevent them working with vulnerable people.

Requires improvement

Is the service effective?

Our findings

Staff did not demonstrate a good understanding of the principles of the Mental Capacity Act 2005 (MCA) and how the Deprivation of Liberty Safeguards (DoLS) worked. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision because of a cognitive impairment, a best interest decision is made involving people who know the person well and other professionals, where relevant. The Deprivation of Liberty Safeguards are part of the Act. The DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict or deprive them of their freedom.

At the time of the inspection the service had made applications to authorise restrictions for 12 people. However, they had not identified that administering a person's medicine covertly, so they didn't know they were taking medicine, was a deprivation of their liberty. We saw the care plans for one person whose medicine was administered covertly, who had an assessment stating they did not have capacity to consent. The care plan stated "document signed by GP", with no other information about who was involved in making the decision, no record of a best interest decision meeting and no application to authorise this deprivation.

We saw that other people had general capacity assessments, which were not decision specific in line with the principles of the MCA. For example, one person had a capacity assessment which stated they "lacked cognitive ability to weigh up information relevant to a decision", with no details of what the decision was and who was involved in making the decision. We spoke with two nurses responsible for completing the capacity assessments who were not aware that capacity assessments needed to be decision specific.

This was a breach of regulation 11 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they enjoyed the food provided by the home and were able to choose meals they liked. Comments included, "There's always a choice of meals and they would do something different for you if you wanted it". We observed a mealtime in different areas of the home during the inspection. In the old building the meal was a relaxed, social occasion, with laughter and chatting. The dining room was attractively presented, with table settings and glasses.

The dining experience for people with dementia was less positive. There were insufficient dining tables to allow everyone to eat their meal there, meaning some people were left sitting in a chair they had been sitting in all morning to eat their lunch. When given a choice, two people expressed a wish to eat at the table. However, one of these people was pushed to the table in their wheeled arm chair and was not offered the option of sitting in a dining chair. This meant they were not at the correct height for the table. There were no table cloths, table settings or menus displayed, as there were in the other dining rooms. Table mats were dirty when the table was laid and there was a shortage of cutlery. In the dining room three people needed assistance to eat, but there were only two staff caring for 12 people. At one point there was only one member of staff in the dining room as two people needed support with their meal in their rooms. We observed two people who were not positioned correctly to enable them to enjoy their meal comfortably. Due to the lack of staff numbers over the lunchtime, seven people who needed assistance to move were still sat at the lunch table at 2.45pm.

Staff told us they did not receive regular one to one meetings with their supervisor, with comments including "I've not had a supervision for about four years" and "(I have had) no supervision for the last year or two". When we asked one care assistant how they knew whether they were doing a good job or not, they commented that they "don't really know". We looked at the supervision overview record, which indicated regular staff supervision was taking place. On looking at individual supervision records we saw that the majority were group meetings and were focussed on tasks in the service. Whilst staff were receiving regular supervision sessions, their feedback demonstrated that they did not feel supported and did not recognise them as supervision sessions.

Most staff told us they received regular training to give them the skills to meet people's needs, including a thorough induction and training on meeting people's

Requires improvement

Is the service effective?

specific needs, including those with dementia. One member of staff expressed concern that they had been asked to support people in the dementia unit but had not worked there for a long time. The member of staff did not feel they had received a suitable induction or handover to enable them to know people's specific needs. There was a training co-ordinator in the service who kept an overview of the training staff had completed and planned where additional courses were needed.

People told us they were able to see health professionals where necessary, such as their GP, specialist community nurse or dentist. We saw there were records of these appointments in people's care records.

Requires improvement

Is the service caring?

Our findings

People told us staff were kind and did their best, but were hampered by there not being enough of them. One person said they appreciated the friendliness of staff and said they were able to have a laugh and joke with them.

During our observations we saw examples of staff interacting with people in a friendly and respectful manner. This included staff asking people whether it was ok to provide care and assistance before doing so, staff explaining to people what was happening and responding to people's questions and requests for support. However, we also saw staff interactions with people which were not respectful and did not maintain people's dignity.

We saw that one person asked staff what day it was and was given the information by the member of staff. During the discussion staff became aware that the orientation board in the lounge was wrong, showing the day, date and weather for the previous Saturday. Staff had not changed the board by the time we left on the first day of the inspection, and it remained showing Saturday when we retuned for the second day of the inspection.

During our observations one person was distressed and expressed concern about the safety of another person who used the service, as they felt they may fall. Staff said to the person not to worry and to call them if there was a problem. The person informed staff they did not have a call bell and was told one would be brought to them. This conversation took place shortly before 10am, but when we completed our observations an hour later, the person was still waiting for the call bell to be brought to them.

People were not always cared for in a manner which ensured their dignity was respected. One person was observed wearing a cloth tabard all morning following their breakfast. This was left in place until lunchtime, when they continued to wear it. The person's glasses were not clean and they were not offered the opportunity to go to the toilet before lunch, or to wash their hands.

During the visit we heard staff describe people as either "doubles" or "singles", referring to the number of staff needed to provide care to them. This demonstrated a lack of a person centred culture and respect for people. We also heard staff refer to people as if they were not present in the room, when they were.

Requires improvement

Is the service responsive?

Our findings

Care plans were not always fully completed or kept up to date to reflect people's needs. We found that one person had moved into the home two weeks before the inspection, but care plans about their needs had not been completed. This included areas where they had specific needs, such as management of aggression, mobility, nutrition, continence, hygiene, tissue viability, psychological / emotional needs and communication. There were pre-printed care plan forms in the care records for these areas, but they were blank and had not been completed. Staff we spoke with gave differing accounts of how they provided support to this person, particularly in relation to managing aggression when the person became distressed.

Another person had a risk assessment indicating the risk of skin breakdown had increased significantly. Their care plan for skin integrity had been updated after this risk assessment was completed, but stated there had been no changes to their skin integrity. This care plan did not reflect the changes to the person's condition and did not give up to date instructions to staff about how to meet their needs.

A third person had diabetes, which was managed by insulin. The care plan for this person did not include details of the type of insulin they were prescribed, the frequency that their blood glucose levels should be monitored, the care that was needed in the event of their blood glucose levels being too high or low or other care needs related to diabetes.

We observed one person who needed assistance to eat their meal. The person's care plan did not contain any information about this support, or how it should be provided. In the five care plans and associated records we inspected, only one contained details of the involvement of the person or their representative in developing the plan.

Care records in the home were on three different organisation's documentation, which made them difficult to follow and for staff to find the information they needed. Two of the nurses we spoke with said they found the care files difficult to navigate and said they had raised this during a training session. The nurse practitioner we received feedback from told us care plans could be cumbersome to visiting staff and said they sometimes found it difficult to locate appropriate clinical information.

This was a breach of regulation 9 (3) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they were able to keep in contact with friends and relatives and take part in activities they enjoyed. One person commented "There are good activities, including a knitting club which we enjoy. We also have residents' meetings". However, we found that there was little activity for people with dementia. During our observations we saw that people were sitting in the lounge from 9.15am without any interaction from staff for long periods, apart from the morning drinks round. The television was turned on but the sound was turned down and music was playing. This may have been particularly confusing for people with dementia.

There were insufficient activities and social stimulation to engage people and enhance their well-being. We saw that one person propelled their wheelchair towards another person sitting at the dining table. The second person became distressed, shouting at the person to "get off". The member of staff initially asked the first person to leave the other alone, but when this was ineffective got up and physically separated them. Although staff took action to keep the person safe, the lack of social stimulation may have contributed to people's frustrations.

We did not observe any activities taking place during the second morning of the inspection. One relative commented that people really enjoyed the live entertainment, but said this had been reduced from once a week to every two or three weeks. The relative also commented that they saw activities advertised but not actually happening in practice.

One person that was nursed in their room had been receiving daily one to one activities such as a hand massage or nail painting up until the 21 May 2015. There were no entries after this date, suggesting that the only intervention and support the person received was task orientated in relation to meeting their personal care needs and support to eat.

The service had a complaints procedure and we saw there was a record of complaints received. Individual complaints had been responded to by a member of the management

Requires improvement

Is the service responsive?

team and details of complaints was reported through the home's monthly management returns. Four of the five complaints received over the previous six months had one or more aspects relating to low staffing levels.

Inadequate

Is the service well-led?

Our findings

The home did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. The regional manager told us a new manager had been recruited and was due to take up their post at the end of June 2015. The regional manager said that she and the regional support manager had been providing management cover since the previous registered manager left the service in May 2015.

Since the service was registered under the Health and Social Care Act 2008 in October 2010 the home had been in breach of regulations for 21 months. Since August 2014 the service had been in breach of regulations relating to staffing and the provider had not taken effective action to resolve the issues. There have been six inspections since the service was registered. Four of these inspections have found the service to be in breach of regulations. The provider has not demonstrated their ability to manage the service effectively and meet their legal requirements.

People who use the service told us about their concerns with the staffing levels in the home. When we asked whether they had discussed these concerns with managers of the service, one person replied, "What's the point, they must know. If I tell them I'm just telling them what they already know". We saw that four of the five complaints received over the previous six months had one or more aspects relating to low staffing levels. Despite this pattern of concerns, action had not been taken to effectively manage the situation and ensure the provider was meeting their legal obligations.

Staff we spoke with demonstrated clear values about how they would like to care for people, but expressed frustration that staffing levels meant they were not able to put them into practice. One care assistant told us, "We don't see the temporary managers. There is no back up from anyone at the moment and I don't know what the values of the organisation are". Another care assistant told us that the regional support manager had been "pretty good" when helping to deal with issues caused by staffing levels. However, the cause of the problems remained and there were not enough staff to provide the care that people needed. A third care assistant told us the home needed more "management direction".

The service had a quality assurance system and a variety of audits to assess the level of service that was being provided. However, these did not effectively identify and manage the issues that we highlighted during the inspection in relation to staffing, infection control, identifying and managing risks, management of medicines and planning care with people. We saw that audits of care plans had not been fully completed. For example, care plans relating to the Mental Capacity Act, mobility and nutrition had not been audited. Our review of the care plans and associated documents found concerns in all of these areas.

This was a breach of regulation 17 (2) (a) and (b) 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 11 HSCA (RA) Regulations 2014 Need for consent The registered person had not ensured they acted in accordance with the Mental Capacity Act 2005 where people were not able to give consent to care and treatment because they lacked capacity to do so. Regulation 11 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person had not ensured they carried out a needs assessment with people and designed care or treatment with a view to achieving people's preferences and ensuring their needs are met. Regulation 9 (3) (a) and (b).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not ensured, risks to people were identified and mitigated where possible; ensured the proper and safe management of medicines; or identified and assessed the risk of infections, including those that are health care associated.

The enforcement action we took:
Warning notice served.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had not ensured there were systems or processes that were operated effectively to assess, monitor and improve the quality and safety of the service provided.

The enforcement action we took:
Warning notice served.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person had not ensured there were sufficient staff deployed to meet the needs of people using the service.

The enforcement action we took:
Warning notice served.