Anchor Carehomes Limited

The Cedars

Inspection report

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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?	**Requires Improvement**

Summary of findings

Overall summary

We completed an unannounced inspection at The Cedars on 19 and 20 October 2017. At the last inspection on 09 November 2017, we found a breach in regulations because people were not consistently treated with dignity and respect. We asked the provider to take action to make improvements. At this inspection we found that there had been some improvements in this area. However, we identified further breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as we could not be assured that people received safe care and treatment and improvements were needed to the way the service was managed. You can see what action we told the provider to take at the back of the full version of the report.

The Cedars are registered to provide accommodation with personal care for up to 42 people. People who use the service may have physical disabilities and/or mental health needs such as dementia. At the time of the inspection the service supported 34 people.

There was a registered manager at the service. However, the registered manager was not available during the inspection and the service was being managed by a regional support manager and district manager. 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. Our records showed another manager who was previously employed by the provider was still showing as a registered manager. The provider told us that they had requested that this manager deregister with us (CQC), but this had not been completed.

Risks to people's health and wellbeing were not consistently managed or followed by staff to ensure people were supported safely.

We found that medicines were not always managed in a consistent and safe manner and they were not always administered as prescribed.

People were not consistently protected from the risks of abuse because staff had not always followed the provider's policy for recognising and reporting possible abuse.

The provider did not have effective systems in place to consistently assess, monitor and improve the quality of care. This meant that poor care was not always identified and rectified by the registered manager and provider.

We received mixed experiences from people and their relatives about the availability of staff. However, during the inspection we saw that there were enough staff available to meet people's needs in a timely way.

Staff told us they received training. However, we found that some of the training they had received was not effective and improvements were needed to ensure staff had sufficient knowledge to support people safely.

Some improvements were needed to ensure the provider had evidence that people were supported with decisions about their care and treatment by legally appointed representatives.

People did not always receive caring support because the provider had not ensured that they were protected from potential harm.

Improvements were needed to ensure people's end of life wishes were taken into account to ensure they received care that met their wishes at this time of their lives.

People and their relatives knew how to complain. However, some relatives were unhappy with how complaints had been handled. The provider had recognised the shortfall in complaint handling and improvements were being made to ensure that complaints were handled in line with the provider's policy.

Improvements were needed to ensure people felt involved in the planning and reviews of their care. Reviews of people's care were not always effective in identifying a change in people's needs.

Systems were in place to ensure that people received the least restrictive care and treatment to keep them safe and staff understood and followed the Mental Capacity Act 2005.

People were supported with their nutritional needs and action was taken to ensure people at high risk of malnutrition were supported effectively.

Advice was sought from health and social care professionals when people were unwell, which was followed by staff.

People's choices were promoted and respected by staff. People were treated with dignity and respect and their right to privacy was upheld.

People were supported to access hobbies and interests that were important to them.

The provider had identified the shortfalls in the quality of care and had implemented an improvement plan. This showed that the provider was working towards improvements to the care people received.

People, relatives and staff felt able to approach the new management team and the provider had asked for feedback and been open about the improvements needed.

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 safe.

People were not protected from the risk of harm because their risks were not always planned, managed or monitored to keep them safe. Medicines were not always managed safely.

People were not consistently protected from the risk of suspected abuse, because some incidents that may constitute abuse had not been investigated and reported as required.

We received mixed experiences from people and their relatives about the availability of staff to meet their needs. However, we found there were enough staff available to keep people safe during the inspection.

The provider followed safe recruitment procedures to keep people safe from potential harm.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Some improvements were needed to ensure staff were competent to carry out their role and training received was being followed correctly.

Some improvements were needed to ensure the provider had evidence that people were supported with decisions about their care and treatment by legally appointed representatives.

Systems were in place to ensure that people received the least restrictive care and treatment to keep them safe and staff understood and followed the Mental Capacity Act 2005.

People were supported effectively with their nutritional risks and health professionals' advice was sought to ensure people received effective care.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us staff were caring. However, people did not always receive caring support because they were not always protected from potential harm.

Improvements were needed to ensure people's end of life wishes were taken into account to ensure they received care that met their wishes at this time of their lives.

People's choices were promoted and respected by staff. People were treated with dignity and respect and their right to privacy was upheld.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People and their relatives knew how to complain. However, some relatives were unhappy with how complaints had been handled. The provider had recognised the shortfall in complaint handling and improvements were being made to ensure that complaints were handled in line with the provider's policy.

Improvements were needed to ensure people felt involved in the planning ad assessment of their care. Reviews of people's care were not always effective in identifying a change in people's needs.

People were supported to access hobbies and interests that were important to them.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider did not have effective systems in place to consistently assess, monitor and improve the quality of care. This meant that poor care was not always identified and rectified by the registered manager and provider.

Systems in place to monitor accidents and incidents were not being followed or managed to reduce the risk of further occurrences.

The provider had identified the shortfalls in the quality of care and had implemented an improvement plan. This showed that the provider was working towards improvements to the care people received.

People, relatives and staff felt able to approach the new

management team and the provider had asked for feedback and had been open about the improvements needed.

The Cedars

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 was 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 19 and 20 October 2017, and was unannounced. The inspection team consisted of three inspectors, which included a pharmacy 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.

Why we inspected – The inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk of falls. This inspection examined those risks.

We also reviewed other information we held about the service. This included other notifications about events that had happened at the service, which the provider was required to send us by law. For example, safeguarding concerns and deaths at the service. We gained information from local authority commissioners to gain their experiences of the service provided.

We spoke with eight people and five relatives and a visiting professional. We also spoke with nine care staff, a deputy manager and the regional support manager, district manager and director.

We observed how staff supported people throughout the day and how staff interacted with people who used the service. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We viewed eight records about people's care and 12 people's medicine records. We also viewed records that

showed how the service was managed, which included quality assurance records, improvement plans and six staff recruitment and training records.

Requires Improvement

Is the service safe?

Our findings

We found that people's risks were not always managed or mitigated to keep them safe. For example; one person's care plan stated they required a chair sensor in place to alert staff that they were mobilising and also a pressure relieving cushion to be used 'at all times' to lower their risk of pressure damage. This person was at high risk of pressure damage and had a small area of soreness on their sacrum. During the morning of the 19th October 2017 we saw that this person was not sitting on a sensor mat or pressure relieving cushion whilst they were in the dining area or in the lounge area for a period of three and a half hours. We saw that staff supported this person to sit on their pressure cushion at 12 noon. However, this person was not sitting on a sensor mat. We asked the Deputy about this and action was taken to ensure the person had a sensor in place and we were told that staff had been unable to find a sensor for this person and staff had forgotten to place a pressure cushion under the person as required. This meant that this person's skin integrity and mobility risks were not managed or mitigated in a prompt manner to keep this person safe from harm.

Another person's risk assessment stated that they required a pillow under their feet and specialist pressure boots to be worn 'at all times' to lower their risk of pressure areas. This person was at very high risk of pressure areas developing and currently had a pressure sore on their ankle which was being treated by the district nurse. During the two days of the inspection this person had not been supported to wear their pressure relieving boots and we did not see their feet being supported by a cushion as stated in their risk assessment. Staff we spoke with told us that this person needed their pressure relieving boots on at all times and could not explain why the person had not been supported to manage this risk. This meant that this person was at risk of harm because their plans of care had not been followed to mitigate the risks to their skin.

We found that people's falls prevention plans were not always up to date and had not been updated after they had fallen. For example; one person's fall prevention plan stated that they could mobilise with a stick. This information conflicted with their mobility care plan which stated the person needed support of two staff to stand and to be transferred to a wheelchair. Staff we spoke with knew the person's needs well and knew that they could not mobilise with a stick. However, there was a risk that this person was at risk of potential harm if supported by an agency member of staff who was not aware of this person's change in needs. This meant that there was at risk that this person's mobility needs would not be managed safely.

We also saw that during the period of June 2017 to September 2017, the incident records did not show that any action had been taken to update care plans and risk assessments to ensure that people's risk of falls was lowered. The Regional Support manager told us that as part of their improvement plans they had ensured that team leaders had received a copy of the fall preventions and post falls checklist. Staff had not been aware of this guidance previously that should have been in place to ensure that appropriate actions were taken by staff to keep people safe from harm. This meant that staff had not been provided with appropriate guidance to manage people's risk of falling. This was now in place but we were unable to assess whether this was effective in ensuring people's safety.

We found that people were not always supported by staff consistently when they displayed behaviour that

challenged. Care plans we viewed did not provide sufficient guidance for staff to follow to provide appropriate support when people displayed behaviour that challenged. For example; two people's daily records that we viewed showed that they had displayed behaviour that challenged towards staff and other people who used the service. We viewed these people's care plans and there was no care plan in place that gave staff guidance on how to support these people when they displayed these behaviours to ensure other people who used the service and staff were protected from potential harm. Staff we spoke with gave inconsistent accounts of how these people needed to be supported, which did not always match the care plans and we were unable to assess which support was the most appropriate. This meant that people received inconsistent and inappropriate care because people's care needs were not planned to keep people safe from potential harm.

Prior to our inspection the provider had recognised that there were issues with how medicines were managed at this location. The provider had introduced strategies to ensure the management of medicines improved and these included daily auditing of medicines, refresher medicines training and competency assessments for the care staff. We found the systems introduced were starting to improve the management of medicines. We found the administration records for the oral medicines were good and were able to demonstrate people were getting their oral medicines at the times they needed them. However we found the administration records for the topical medicines/treatments were not able to demonstrate that they were being applied in accordance with the prescriber's instructions.

We found where people had to have their medicines administered by disguising them in food or drink the provider did not have all of the necessary safeguards in place to ensure these medicines were administered safely. For example, we found the provider was not always able to demonstrate what advice they had taken from a pharmacist on how the medicines could be safely prepared and administered. We also found that there was no written information to tell staff how to carry out this process safely and consistently.

Medicines were not being stored correctly to maintain their effectiveness. We found the refrigerator temperatures were not being measured on a daily basis. Where temperatures were being taken we found the maximum temperature of the refrigerator was consistently above the expected maximum temperature. We also found the refrigerator temperature had dropped below the expected minimum temperature on six occasions since the 30 September 2017 but no action had been taken to ensure the safety of the medicines being stored in the refrigerator. The refrigerator was storing temperature sensitive medicines called insulin and its efficacy can be affected when it is exposed to temperatures below the minimum temperature of two degrees Celsius. We examined the blood sugar records for people who were prescribed insulin to see if this had had an impact on the management of their diabetes and it appeared it had not. However, people had been placed at risk of potential harm. The management team took the decision to immediately replace the affected insulin in order to reduce the risk of these medicines becoming ineffective.

We saw that information available to the staff for the administration of 'when required' medicines was not detailed enough to ensure that the medicines were given in a timely and consistent way by the care staff. For example; one person suffered periods of anxiety and had been prescribed an 'as required' medicine to be administered. The protocols in place did not give staff sufficient to guidance to understand when this person needed their medicine. We spoke to a member of the care staff and they agreed that further information would help them to better understand and decide when it would be most appropriate to administer these medicines. This meant that people were at risk of not receiving their medicines when required.

The above evidence shows that people's risks were not planned, monitored or mitigated in a way that kept them safe from harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that potential acts of abuse had not always been reported as required. For example; a behaviour chart we viewed showed that one person had been hit whilst sitting at the table by another person who used the service. This had not been recorded in the incident file or reported to the safeguarding team. On the first day of the inspection the inspector observed a person who used the service become verbally aggressive towards another person who used the service. Staff intervened and calmed the person down. However, the records we viewed and on discussion with the Regional Manager showed the staff member had not reported this as potential abuse. We were told by staff that this person often displayed verbal aggression towards staff and people. This meant that people were at risk of continued abuse because staff had not recognised when to report suspected abuse.

We found that some unexplained bruising had been investigated and reported as a safeguarding concern. However we found that there were instances where unexplained bruising had been identified by staff, but these had not been reported or investigated. For example; one person's skin records showed that they had unexplained bruising on two occasions which had not been reported or investigated. Staff had recorded on another person's records that another person had unexplained bruising to their eye. This person's skin records stated 'monitor person's skin'. However, the management were unaware of these incidents, which meant they were unable to undertake an investigation as to the cause and the safeguarding authority had not been made aware. We saw that the new management had implemented 'Responding to a bruise' guidance for staff to follow. Staff had not followed this new guidance which meant that people were at risk of potential abuse because episodes of unexplained bruising had not been reported and acted on to ensure people were kept safe from harm. The District Manager told us that they were currently implementing these procedures with staff which needed to be imbedded into the service. This meant that people were not always protected from the risk of harm.

The above evidence shows that people were not always safeguarded from potential abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback from people and relatives we spoke with about the staffing levels at the service. One person said, "It's half and half. They could do with some more staff they soon seem to vanish. I do sometimes have to wait to go to the toilet". Another person said, "Staff are always there if you need them" and, "I find there are generally enough staff about to help me".
One relative said, "Sometimes I wouldn't say there's not enough staff on the floor and sometimes it's hard finding anybody. It's a bit hit and miss" Another relative said, "Sometimes I'll be in and there will be only one carer on the floor and one carer on their break, but at times when people are here looking at them, there's suddenly five staff available".

However, during the inspection we saw there were enough available to support people with their assessed needs at a time they needed it and we were unable to evidence a shortage in staff. For example; we saw people were supported with their needs in a timely way and staff provided support in an unrushed way. We saw people were supported to access the toilet when needed and were supported with time and patience when being assisted to eat. We found that there were agency staff providing support to people and asked the regional support manager how they ensured people received care from a consistent staff group. We were told that there were some staff shortages and the provider was actively recruiting where able and when they used agency staff they ensured that there was consistency by requesting the same agency staff members are used where possible.

Requires Improvement

Is the service effective?

Our findings

Staff we spoke with told us they had received an induction when they began their employment at the service. Staff also told us that they had undertaken training to help them carry out their role effectively. However, we found that this training was not always imbedded in to the support staff provided for people. For example; we found that staff had received training in safeguarding people from abuse. Staff told us how they recognised signs of abuse, such as bruising and how they would report these signs to the management. However, we identified that there were some instances where unexplained bruising had been noted on people's daily records, but these had not been reported to management, which meant these were not investigated or reported to the safeguarding authority. This meant that some improvements were needed to ensure that staff understood and followed training provided in all areas of practice.

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.

Some people were unable to understand some decisions about their care and we checked that the provider was meeting their responsibilities under the Mental Capacity Act 2005. We saw mental capacity assessments had been carried out when people lacked capacity, which contained details of how staff needed to support people in their best interests. Staff we spoke with understood their responsibilities under the MCA and what it meant for people they supported. However, we found that some areas of the MCA required improvements. For example; we saw that some people's records showed relatives had Lasting Power of Attorney (LPOA) over their relatives care and welfare. LPOA gives a representative the authority to act for another person in specified matters. In these circumstances the relative would need to have authority to make decisions about the person's care and welfare. We asked the regional support manager to provide a copy of the LPOA's to ensure they had evidence of relatives' legal right to consent to their relatives care and treatment. The regional support manager was unable to provide evidence for two of the people whose records stated their relatives had LPOA. This meant that some improvements were needed to ensure that decisions were being made by representatives that had the legal authority to do so.

People told us that they consented to their care and staff asked their permission before they provided support. One person said, "Yes they ask me what I need help with. I can't fault the staff because they're good to me" Another person said, "Yes, they do ask me". We observed staff talking with people in a patient manner and gained consent from people before they carried out support. This meant consent was gained from people to make decisions about their care and treatment.

We saw applications had been made for Deprivation of Liberty Safeguards (DoLS), where people had restrictions in place to keep them safe. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We

checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff were aware of the restrictions in place and we saw staff support people to keep them safe from harm in line with their individual DoLS. For example; one person had a condition in their DoLS that stated they needed a referral to a health professional to consider medicine to alleviate anxieties. Staff understood this condition and we saw in the records that this had been acted on because the person had been reviewed by a visiting G.P. This meant that people were supported in the least restrictive way and in their best interests.

People told us they enjoyed the food at mealtimes. One person said, "I like the food, it's good and I enjoy it". Another person said, "I am offered a choice at mealtimes. They [staff] always make sure I've got some food. I've got no complaints with it". Another person said, "I have always liked cereal and toast in the morning and that is what I have. I get offered a hot breakfast but I like to have what I've always eaten and the staff respect that". We observed breakfast and lunch and saw staff listened to what people wanted and promoted people's choices. For example; we saw that staff showed people two plates of food at lunch containing different meals and people were able to look and choose before it was served to them. We saw support plans were in place that detailed the individual support people needed to ensure their nutritional needs were met. For example, people who had been assessed as a high risk of malnutrition had a support plan in place that detailed the actions required by staff. We saw that people who were at risk of malnutrition were encouraged and assisted throughout mealtimes and staff completed food and fluid intake charts to monitor the amount that people ate and drank. This meant people were with their nutritional needs to keep them healthy.

People told us they were able to see health professionals when they needed to. One person said, "The staff arranged for me to see the doctor the other day because I was feeling unwell and I see a chiropodist when I need to". The records we viewed showed that people had accessed health professionals such as; dieticians, opticians, chiropodists and consultants. We also saw that guidance was sought from health professionals and this had been acted upon so that people were supported to maintain their health and wellbeing. For example, staff had noticed that one person was having difficulties eating their food and this sometimes caused them to cough. They had raised this with the management as they felt this person was at risk of choking. We saw that a referral had been made for an assessment by the speech and language therapy team and this person's care plan had been updated to ensure they were given softer food without lumps until they had been assessed. We saw this was followed by staff on the day of the inspection. This meant that people were supported to access health professionals to maintain their health and wellbeing and advice sought was followed by staff.

Requires Improvement

Is the service caring?

Our findings

We found instances that did not always promote a caring environment for people. For example; staff had not always recognised potential abuse, which meant people were not always supported in a safe and caring way. We also saw that people had not been supported to lower risk to themselves and others. This showed that the provider had not always ensured that people were cared for and protected from potential harm.

We found that care plans we viewed did not always have details of people's end of life needs and wishes. For example; we were unable to ascertain what people's preferences during their end of life would be and this important information was not always available for staff. This meant that staff would not be aware of people's wishes if they became unwell and were not able to communicate these effectively. This meant that improvements were needed to ensure that people's end of life care was considered and planned in line with their preferences.

People told us that staff were kind, caring and friendly towards them. One person said, "The staff are very nice and they treat me very well. I feel cared for because staff would do anything for me". Another person said, "The staff are lovely, very friendly and helpful". We saw staff interacted with people in a caring way and gave people time when they supported them. For example; we saw staff sitting with people when they needed to talk with staff and staff asked people how they were feeling and if they were okay. People were seen smiling and were comfortable in staff presence and enjoyed a laugh and joke with staff.

People told us staff gave them choices in the way they received their care. One person said "I'm not rushed what time I get up in the morning and I take my own time. I just please myself". Another person said, "I do a lot for myself and staff listen to what I want if I need any help". People told us and we saw that people were dressed individually and were given choices in the clothes that they preferred to wear. We saw people were given choices by staff throughout the day and staff listened to people's wishes. During lunch we saw that people were given choices of drinks and meals. People were shown the choice of meal which helped people who had difficulty making choices and ensured they were supported in a way that met their needs.

People told us they were happy with the way the staff supported them treated them with dignity and respect. One person said, "I am treated with dignity. For instance, when I go on the toilet I cover my knees with a towel". Another person told us that staff always spoke with them in a caring and dignified way and gave them time to respond to questions. People also told us that they were able to access their own rooms throughout the day if they needed some time alone. One person said, "I can go to my room if I need to and when I don't feel like company. The staff check on me though to make sure I'm okay. We saw that staff supported people in a dignified way. For example when staff supported people to move using a hoist the staff ensured that they were covered and their dignity was upheld. We also saw that when people had eaten and food had been spilt on clothes staff ensured people were supported to change if required. This meant people were treated with dignity and respect and the right to privacy was up held.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us they knew how to complain and they have made complaints in the past. However, the majority of people and relatives stated that their complaints had not been dealt with by the registered manager. One person said, "I know how to complain but I'd sort it myself and there's no point going to the management". A relative said, "I've spoken to the managers about different things that I didn't think were right at the time. I don't think they did anything about it though. It's settled down more since the new managers have arrived". We viewed the provider's complaints log and found that there were no complaints logged by the registered manager between April 2017 and September 2017, although people and relatives told us that they had numerous complaints. This meant that complaints made during this time had not been acted on to make improvements for people.

We saw that during the period of September to the date of the inspection, where complaints had been received there had been action taken by the management to investigate people's concerns. A relative told us that they felt more confident in the management and they had noted that some improvements had been made. This meant that some recent improvements had been made to ensure complaints were handled in line with the provider's complaints procedure and acted on to make improvements to care. However, we were unable to assess whether these improvements would be sustained and we will check this at our next inspection.

We received a mixed response from people and their relatives regarding their and reviews of their care. One person said, "'Sometimes they do, half and half". Another person said, "It's only changed when the GP comes in". A relative said, "Not enough I don't think; they do talk to me about my relative but not enough. They never call me in for a review, they should but they don't". We saw that some reviews had been undertaken in line with the improvements noted in the provider's improvement plan. However, we found that these were not always effective in ensuring that people's care was up to date. For example; one person's mobility needs had changed and we asked staff about this person who told us this person needed two members of staff to support this person safely as they were unable to walk. However, we found the care plans and risk assessments had not been updated to show this change in their needs. The provider currently used agency staff due to a shortfall in permanent staff and there was a risk that people would receive inconsistent support because people's reviews had not ensured people's records contained up to date information about people's needs. This meant there was a risk of people receiving inconsistent care because their review did not reflect the changes in their support needs.

People told us that staff knew their preferences in care and provided support in line with their wishes. One person said, "The staff are very good and they know me well and the things I like". Another person said, "The staff help me in a way I like things done. It's good how they know me". The records that had been updated contained information about people's preferences, which included people's likes and dislikes. For example; one person care plan stated that they had always been a quiet person and they liked to spend time on their own. We saw this person spent time in their private room and staff respected this, whilst periodically going to check that the person was okay. Another person's care plan gave details of their religious beliefs and how staff needed to ensure that they were informed if the vicar attended the home as they liked to speak with

them. The care plans were in the process of being updated to ensure that all care plans contained details about people's preferences in care and we will assess the progress of this at our next inspection.

People told us that there were some activities on offer such as; painting, crafts, crosswords and chatting with staff. One person said, "I love to do crosswords and word searches, it keeps my brain active. I always have enjoyed this and staff make sure I have plenty of crosswords to do". Another person said, "The staff come round after breakfast and there are different tables where you can be involved in different crafts and interests. I like to paint so I go to that table and sit with staff". One relative told us that there used to be an external entertainer who visited the service occasionally but this had not happened for some time. The relative felt that this would provide more stimulation for people within the home. We spoke with the regional support manager who told us that this is something they would consider in the future if people who used the service wanted this type of activity.

Requires Improvement

Is the service well-led?

Our findings

Prior to the inspection site visit we saw that the provider was displaying their rating on their website. However, we found that the rating was not on display within the service. We also found that the incorrect registration documents were on display and showed the previous provider details. We informed the management team of this on the first day of the inspection and we were told this was an oversight and they ensured that the rating was on display by the 2nd day of the inspection. However, the displaying of the previous ratings for the service is a requirement to ensure that providers are open and transparent about the improvements they needed to make.

This meant that the provider had failed to comply with display ratings requirement under Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Offence under Regulation 22 of the 2014 Regulations.

We saw the provider had an improvement plan in place and some improvements had been made since they had identified the shortfalls in the quality of the service provided. However, there were still some areas that needed further improvements and these improvements needed to be sustained. For example; medicines had improved and the audits in place had identified concerns and detailed the actions that had been taken to make improvements. We found that there were still some concerns regarding medicines and further improvements were needed to ensure these were imbedded and sustained.

We also found that accident and incident monitoring was not yet in place. We looked at the records of people who had suffered falls and there was no information to show that this had been analysed to ensure that appropriate action had been taken to lower the risk of further falls. The provider had recognised this and a plan was in place to analyse accidents and incidents to ensure that appropriate action was taken to lower risks to people. We could not assess if this was effective as this had not yet been implemented. This meant that there was not a system in place to analyse accidents and incidents to ensure that the risk of further occurrences was mitigated to keep people safe from harm.

We found that improvements to people's care records were ongoing and the provider's improvement plan stated that all care plans would be reviewed and updated by the 31st October 2017. Some of the care files where we had identified concerns had been reviewed, which meant that the reviews were not always effective in identifying areas that needed to be updated to provide safe and effective care. This meant that the system in place to review and update people's care needs was not always effective in identifying and recording a change in people's needs.

We found that there was not a system in place to identify potential safeguarding issues. For example; the daily records we viewed identified that staff had recorded that some people had unexplained bruising. However, they had not always reported these concerns to the management in line with the provider's policies. The management team were unaware of these incidents, which meant that possible safeguarding concerns had not been investigated and reported to the local safeguarding team. This meant that effective systems were not in place to identify potential abuse and mitigate the risks of further occurrences.

The above evidence shows that effective systems were not in place to monitor, manage and mitigate risks to people and protect them from harm. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to the inspection visit the provider had identified concerns with the quality of the service provided. A district manager from another of the provider's locations and a regional support manager had been moved to the service to provide support with the monitoring and management of the service. The district manager alerted the safeguarding authority and CQC when they identified the amount of concerns within the service that needed rectifying, alongside an improvement plan which showed how they planned to make improvements. During the inspection we saw that there had been some improvements made in line with the improvement plan and these improvements were ongoing. For example; we saw that an infection control audit had been carried out an identified that systems needed to be implemented to ensure a clean environment. We saw that chairs had been replaced and all carpets in communal areas were being replaced. We also saw that monitoring of people's experiences during mealtimes had been completed and actions were in place to ensure people were supported effectively and a floor management plan had been recently implemented to ensure that people's needs were met effectively. The Director had a clear oversight of the concerns and regularly visited the service to ensure that improvements are being made. This showed that the provider had been open and transparent about the concerns they had identified and were working towards ensuring people had an improved quality of care.

People and relatives stated that they had not previously been asked for their feedback about the care provided. Some people and relatives told us they had found that the registered manager was not always approachable and effective in dealing with their concerns. However, they told us that the management team had recently held a meeting to explain where they had found concerns and how they were working to make improvements in a number of areas. One relative said, "I found the meeting we had recently really helpful, it was a very open meeting and I was quite vocal to get my point across as I have been unhappy about the care for some time but nothing had seemed to change. I felt enthused by the improvements and the new management team. It is just a matter of waiting and seeing if things change". Another relative said, "I am hopeful that the improvements will change things for my relative and I do feel that the management team want to make these improvements". This meant that action had been taken to ensure that feedback was gained from people and their relatives to inform service delivery and to ensure they are up to date with the areas that required improvements.

Staff we spoke with told us that the management team had arranged staff meetings and they were available and approachable. One staff member said, "The team meetings have been good, they have been an opportunity to discuss our concerns alongside the issues raised by the management team". Another staff member said, "I feel able to discuss any concerns with the management team as I felt it has been difficult to raise things previously. I can see where things are getting better". Staff also told us that they had received supervisions under the management team. One member of staff said, "I had informal chats with the registered manager and I have had recorded supervisions with [regional manager's name]". Staff told us that they have recently had their performance reviewed and if they have been informed if they need to make improvements. One staff member said, "We get told if we need to improve, it is helpful. Morale has been low but I think this is improving bit by bit". This showed that improvements were being made to ensure staff performance was monitored and staff were given the opportunity to be involved in the improvements required at the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always safeguarded from potential abuse because potential abuse had not been reported or investigated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems were not always in place to monitor and manage the service, which meant risks to people were not mitigated.

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 12 HSCA RA Regulations 2014 Safe care and treatment People's risks were not always managed and mitigated to protect them from the risk of harm. Medicines were not always managed safely.

The enforcement action we took:

We served a warning notice asking the provider to make improvements within a specified timescale.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider was not displaying the rating of their previous inspection within the service as required.

The enforcement action we took:

We served a fixed penalty notice.