The Orders Of St. John Care Trust

OSJCT 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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The Cedars provides accommodation and personal care for up to 49 older people. At the time of our inspection there were 32 people living in the home and two people in hospital. The inspection took place on 14 and 15 March 2017 and was unannounced.

A registered manager was not in post when we inspected the service. 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. A manager from one of the provider's other homes was managing the service and this manager has since become the registered manager for the service. The manager was present and approachable throughout our inspection.

At our previous inspection the home received a rating of requires improvement and were in breach of three Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection some improvements had been made but we found that the home had a repeated breach and further breaches of the regulation were identified. You can see what action we told the provider to take at the back of the full version of the report. We are taking further action in relation to this provider and full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Risk assessments had not always been put in place where there was an identified need. We saw some risk assessments were not being reviewed within the designated time frames to ensure they remained in line with people's changing needs.

The home did not have effective measures in place to be consistent in their management of behaviours that challenged. Staff had not received training in this.

The recruitment of staff had remained inconsistent since the last inspection which had impacted on the care people received and the pressures staff felt.

Staff had a good understanding of how to identify safeguarding concerns and act on them to protect people. People we spoke with told us they felt safe living at The Cedars commenting "If I press the buzzer I don't have to wait too long before someone will come and answer it. I do feel safe knowing there is help available if I need it."

Staff had not always been given the opportunity to attend training and supervisions in order to develop and maintain their skills and receive support. The manager was in the process of addressing this.

The home had not always obtained the appropriate consent before taking decisions on behalf of people to ensure care was given in line with their preferences.

People's healthcare needs were regularly monitored. There was evidence of regular consultations with health care professionals where needed and we saw staff seeking advice when needed.

People spoke positively about staff and the care they received. We saw that people were comfortable in the presence of staff and had developed caring relationships. One person told us "The staff are very kind to me, they look after me well."

The service had remained in breach of the Regulation for ineffective recording in care plans and monitoring records. There was often inconsistent or conflicting information which made it hard to ascertain a person's most current needs.

The service had experienced a period of instability and this had impacted on people, their relatives and staff. A manager from one of the provider's other homes was providing management support to the home and since we visited the service has become the registered manager. The manager was working hard to address areas of concern she had identified and an action plan was in place. Staff spoke positively about the support they were now receiving and told us the manager was approachable and available should they need to speak with her.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risk assessments had not always been put in place where there was an identified need. We saw some risk assessments were not being reviewed within the designated timeframes to ensure they remained in line with people's changing needs.

The home did not have effective measures in place to be consistent in their management of behaviours that challenged.

The recruitment of staff had remained inconsistent since the last inspection which had impacts on the care people received and the pressures staff felt.

Staff had a good understanding of how to identify safeguarding concerns and act on them to protect people.

Is the service effective?

Requires Improvement

The service was not effective.

Staff had not always been given the opportunity to attend training and supervisions in order to develop and maintain their skills and receive support.

The home had not always obtained the appropriate consent before taking decisions on behalf of people to ensure care was given in line with their preferences.

People's healthcare needs were regularly monitored. There was evidence of regular consultations with health care professionals where needed.

Is the service caring?

Good

The service was caring.

People spoke positively about staff and the care they received. We saw that people were comfortable in the presence of staff and had developed caring relationships.

Care was delivered in a way that took account of people's individual needs and in ways that maintained their independence.

Staff supported people to make their own decisions about their day to day life.

Is the service responsive?

Requires Improvement

The service was not responsive.

The service had remained in breach of the Regulation for ineffective recording in care plans and monitoring records. There was often inconsistent or conflicting information which made it hard to ascertain a person's most current needs.

The home had not been able to maintain staff to provide consistent activities which had an effect on people's social engagement. The manager was in the process of addressing this.

People's concerns and complaints were encouraged, investigated and responded to in good time.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service had experienced a period of instability and this had impacted on people, their relatives and staff. A manager from one of the provider's other homes was providing manager support to the home and has since registered as the manager.

The manager was working hard to address areas of concern she had identified and an action plan was in place.

Staff spoke positively about the support they were now receiving and told us the manager was approachable and available should they need to speak with her.

Quality monitoring systems were in place and these were being reviewed to ensure when concerns were identified adequate measures would be taken.

OSJCT 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 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 14 and 15 March 2017 and was unannounced. The inspection team consisted of one inspector, a specialist nurse 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. The home was last inspected in January 2016 and received a rating of requires improvement with three breaches of the regulations identified. Before the inspection we checked the information that we held about the service and the service provider. This included statutory notifications sent to us about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

During our inspection we spoke with nine people living at the home, four relatives and friends, 10 staff members, one health professional, the manager and area operations manager.

We reviewed records relating to people's care and other records relating to the management of the home. These included the care records for eight people, medicine administration records (MAR), six staff files, the provider's policies and a selection of the services other records relating to the management of the home. We observed care and support in the communal lounge and dining areas during the day and spoke with people around the home.

Requires Improvement

Is the service safe?

Our findings

Risk assessments had not always been reviewed within the designated timeframes to ensure they remained in line with people's changing needs. For one example one person's fire risk assessment tool, which looked at the assistance needed in the event of an evacuation was meant to be reviewed monthly but had not been done since October 2016. This was the same for one a moving and handling risk assessment. One person's falls risk assessment had recorded four falls in one month, however this assessment had not been reviewed despite the person having had two more falls. This meant the person's falls could not be effectively monitored and assessed to ensure the appropriate preventative measures were taken.

We saw some examples where risk assessments had not been put in place. For example people had access to a toaster and a kettle but this had not been risk assessed to ensure people who had dementia or visual impairments were kept safe when using these. The manager looked for this assessment but could not locate one and assured us this would be completed. One person had been identified as being at risk of self neglect but there was no risk assessment in place to guide staff on how to support this person. This person would regularly refuse meals and personal care and spent most of their time in their room sleeping. Daily records showed they consistently declined personal care and meals. We looked at a timeframe between 3 February and 13 March and saw these behaviours were consistent. This person had received some external professional support and it had been decided that this person needed regular checks put in place. However there was no documented evidence of these checks to ensure these were being completed.

One persons initial assessment stated they were at high risk of falls. The falls prevention care plan however contradicted this and stated the person was at low risk of falls. We saw this person continued to experience falls the most recent having been in March, with no injuries obtained. This had not been recorded on their falls care plan evaluation and a falls analysis sheet had no recorded answer for whether the risk assessments had been updated and the manager informed. Risk assessments from falls did not provide information on the management of risks, this was done in the mobility care plan but did not link to the assessment in recording that the person had been identified as high risk. For example one person's fall risk assessment stated they were at high risk of falls but their mobility care plan did not reflect this and recorded that this person had not experienced any falls. Another person's mobility care plan stated they 'Walk using a zimmer frame and does not require any assistance', however we saw that this person had fallen four times in one month. A falls prevention care plan was in place but this had not been completed correctly and only recorded two of the person's falls. The moving and handling risk assessment and falls risk assessment had not been updated to include all the falls and the falls analysis only recorded one of these four falls. This meant the correct information was not being recorded to ensure risks to people were appropriately managed to keep them safe.

One person's daily records recorded that they 'Wandered' most days. Recordings included statements such as 'Up and wandering again' and 'Feeling low and walking corridors'. We could not see that any interaction or engagement with this person had taken place from the documented recordings. However we saw staff throughout our inspection engaging with this person. This person's mobility care plan said '[X] will walk within the home and can become distressed and at times cause distress to others by entering their rooms'.

On a moving and handling assessment it stated the person 'Does try to climb gates and fences'. We could see no risk assessment in place for this and raised our concerns with the manager who was unaware this information had been recorded and told us she had never known the person to do this. The manager further said this person would often help the housekeepers but agreed it was not documented, and that care plans needed to be rewritten.

We observed that the hot trolley used to take meals to people upstairs was left in one seating area unattended whilst staff took meals to people and was hot to touch for anyone walking past. The manager explained this had been identified as a concern and they planned to buy another trolley which would fit under a counter upstairs that they were turning into a kitchenette area for people. The manager was going to look into this further in the meantime. We saw that people would enter other people's rooms but there was nothing documented on how this was managed and how people who were vulnerable to this were kept safe. We saw that the home had considered moving one person downstairs to monitor more effectively but they had refused and no other actions had been implemented.

Staff kept one person's cigarettes for them in the office. We saw this had an assessment in place and the person's consent had been obtained, however the cigarettes were not kept locked away and there was no record in place to document the amount to ensure the person received all their cigarettes. The manager told us these would now be kept in the safe and a record put in place to document the amount.

We asked staff how people who spent time in their rooms and did not have capacity to use a call bell were able to call for help. One staff told us "In a previous workplace staff were always present and would check. I don't know what happens here." Other staff told us they would check people but were unable to be more specific on the frequency of this. During the inspection we heard one person calling out to staff from their bedroom when they required support. Another person's call bell had been placed behind their head out of reach so if they were able to use this they would not have had it in easy reach when in bed. The manager said hourly checks would be put in place for people who are unable to use their call bell and these would be documented.

This was a breach of Regulation 12 (2) (a) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager spoke about wanting to balance people's rights to take risks, and told us one person who was quite independent had wanted a kettle in their room, so this had been assessed and implemented. The manager said they were creating a kitchen area upstairs for people to use, and always ensured the doors to the garden were open so people could access it as the benefits outweighed the risks.

At our last inspection the home had been in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to equipment repeatedly being left in unsuitable communal areas and insufficient lighting in people's bedrooms which could potentially present as a falls risk to people. The home sent us an action plan of measures they would take to address this. At this inspection we saw the home had taken action to meet the requirements of this regulation. Lighting in the home had been upgraded and people's bedrooms and corridors were lighter. We saw that all equipment including wheelchairs and hoists for transfers were been kept in secure cupboards around the home which were clearly labelled.

The home did not have effective measures in place to be consistent in their management of behaviours that challenged. There were people in the home who at times could be physically or verbally aggressive in their behaviour. No one had a risk assessment in place for staff to follow during these times so they knew how to

support people safely. Staff told us about one person who would frequently display physically aggressive behaviour with one staff commenting "[X] fights you when I try to get him up. We have almost had to get the full body hoist because of it." We reviewed this person's daily records which reported they spent most of their day in their room sleeping and would become verbally and physically aggressive. We saw on three occasions this behaviour had escalated into staff completing an incident form due to the aggression shown behaviour. The measures to take had been recorded as 'Increase activity levels and record more detail of the aggressive episodes'. However there had been no increase in this person's activity levels or records of any interventions until recently when this person had built a relationship with one staff member and was responding well to receiving care from them.

One person's level of aggression in their dependency tool was recorded as 0, however their daily records reported they had 'Thrown a cup of tea', were 'Very vocal' and 'Very difficult to assist with personal care'. We observed this person during one meal time and saw they were throwing their food across the table followed by their plate. One staff member suggested they support the person on a one to one basis as it was disturbing other people but they were told by another staff to take a tray of food to a person's bedroom instead as there wasn't enough staff for this. We looked at this person's daily records the next day and saw this incident had not been recorded by staff. Another person's daily records recorded regular incidents of the person shouting and swearing at staff and going in and out of other people's rooms and being rude. Another person's entries recorded that they had 'Spat out tablets, grabbed staffs wrist and said they would break their arm'. There was no behaviour management care plan or risk assessment in place for staff to follow when these incidents occurred.

It was not clear how staff were recording incidents around people's behaviour. Some staff said in the daily records but we saw this was not always done. Other staff referred to the Antecedent Behaviour Consequence chart (ABC) to record any behaviour (ABC chart is a direct observation tool that can be used to collect information about the events occurring). We saw a couple of people had another tool in place called the 'Cohen Mansfield agitation inventory' which had only been completed twice in October 2016. We saw that staff were not consistent in their response when supporting people. For example one ABC chart showed staff had either 'Told night staff', 'Asked to stop' or 'Reported to manger'. One person's care plan recorded an incident in February when they had become aggressive in another person's bedroom when asked to leave. An hour and half later this person was still not calm and was in the corridor. The action taken by staff was to check the person two hourly, despite them presenting as a potential risk to others. The manager since working with the home had identified improvement was needed around the approach and recording of behaviour management and told us she had called the Mental Health Team to revisit and support.

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

The home had experienced a period of instability from management changes and some staff had left employment which had an impact on the pressures felt by the existing staff. The manager told us she completes the rota and then creates a wish list for any shifts that need covering so staff can pick these up if they wish. The remaining cover was then sought through an agency. The manager told us the same agency was used and this provided staff that had worked in the home previously and were familiar with people.

Staff consistently told us how the home did not have the right levels of staff commenting "No way is there enough staff, it is difficult with agency staff not knowing people. The manager is trying to hire at the moment. The kitchen alone needs two to three people", "It's looking up now, the staff we have are excellent, if we didn't have a strong team it would have been a disaster without having any management support as well", "We are very short staffed at the moment but are recruiting and waiting on people's checks. We need

more staff, the staffing levels and care plan dependencies were done wrong so the staff levels are not set out correctly and there are not enough staff available to take time to correct it", "Lately we have managed and there has been enough. It's been hard on us, but since the manager has been in things look on the up, and we are seeing an improvement in staffing", "I would like more staff, we have safe numbers, but could do more one to one with people if we had the resources" and "We have more staff now and it's freed us up to do our job again. We are beginning to address the staffing overall, the kitchen have been struggling."

During the inspection we observed that there were not sufficient staff to respond to peoples needs in a timely way. There were three observed instances of staff breaking off from administering medicines to respond to people's needs or concerns as no other staff were present. We observed a member of the housekeeping team go to answer a person's calls and was then seen assisting the person to the toilet and explaining that "Everybody else was tied up at the moment."

We saw one person asking for 'help to go to the toilet' and they repeated this numerous times. On the fourth time of asking another person told them to be quiet because "We getting fed up with your continual asking." A staff member came in and then went to make toast in the kitchen but did not respond to the person's calls until we alerted them. On the first day of inspection at 9.40am we observed four people sat at a table in the dining room. One person was trying to eat their toast but had a runny nose and no tissues to hand and did not seem aware of that their nose was running. There were no staff on hand to assist this person. It was 10.13am before this was noticed by a senior staff member who was administering medicines on the ground floor and stopped to attend to this person. One relative told us "There is often not enough, they do seem to be running about a lot." Another relative commented "Ideally it would be great if there was more staff, personal care has been rushed. The manager has told me they are recruiting more and want the right person not just anyone and I respect that."

The manager said a dependency tool had been used to calculate staffing numbers and that they had some people with very high needs, two of which had transferred from the home to receive nursing care. The manager said "Staff do say they are rushed, I'm having a staff meeting to look at this. The staff administering medicines are now on the floor in the mornings ,and we are looking at the structure of the home. When I came in it was a lack of organisation on the shifts, but not now as there are staff on each corridor".

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

Safe recruitment practices were followed before new staff were employed to work with people. Checks were made to ensure staff were of good character and suitable for their role. The manager told us "We are looking for staff who can meet people's needs, who are willing to learn, and have references. I won't take anybody just to fill numbers, they have to be a good communicator".

Medicines had not always been safely managed. There had been 18 medicine errors in the past 12 months, some of which included repeat prescriptions not being ordered in sufficient time and the wrong medicine given to a person. The new manager planned to train additional staff to administer medicines to help reduce the pressure on those already administering medicines. A specialist nurse attended this inspection because of the past history of repeated medicine errors.'

The provider's medicine policy stated that all medicines (brought from home) to be administered, must be documented on people's medicine administration records (MAR's). If the entry was handwritten it must be done in black ink and verified with two signatures. This policy was not being followed by the home. We saw signatures were missing in several instances, four handwritten entries had no signatures and three had one.

One person was receiving a prescribed medicine which had been handwritten on the MAR with the instruction to be given 'In spaced out doses three times in 24 hours'. It had been documented to be given at 7.30am, 12pm and 8pm. We observed the dose prescribed for 7.30am being administered at 11am. Nothing had been written on the reverse of the MAR indicating that it had been given at a different time to that stated on the MAR. This meant the person was at risk of receiving their medicine too soon after the last dose which would impact on the effectiveness of the medicine. We raised this with the staff administering medicines immediately so the person was not given a second dose within such a short timeframe.

We reviewed all the MAR's in place and saw for one person there were gaps in signatures on 8 and 13 March. There was no recorded reason as to why there was a gap which meant it was unknown if this person had received their medicine. We raised this to the manager to address. The home had undertaken their own audit and identified their MAR records were not being recorded as being administered in accordance with MAR instructions. The manager had identified areas of improvement in her action plan. One person requiring regular medicine for a specific health condition did not receive their medicine until an hour after the prescribed time. No information had been recorded on the reverse of the MAR. This was raised with staff who then delayed the next dose. One person had been prescribed one medicine to take weekly. This was clearly indicated on the MAR, but there was nothing recorded to indicate this particular medicine should be given before food and that the person needed to stay upright for stay least 30 minutes after taking it. The provider policy stated that 'Any employee administering medicine to a resident must be aware of both the effects and possible side effects of the medication'. Although this had not been fully recorded staff had the appropriate knowledge and were administering this medicine correctly.

Most of the 'As required' (PRN) medicines did have clear guidance in place to follow and one PRN was very detailed recording that staff were to call an ambulance if after two doses of medicine the person's symptoms had not ceased. However we found that four people did not have a protocol in place for their PRN medicine. The home had undertaken their own audit and identified their MAR records were not being recorded as being administered in accordance with MAR instructions. The manager had identified areas of improvement in her action plan.

People we spoke with told us they felt safe living at The Cedars commenting "I do feel safe knowing there is help available if I need it" and "There are staff around, I can leave my door open and they can come into me if I have a problem." One relative told us "They are safe, everyone has made the effort to get to know him and he knows that. He knows how to call if he needs help and he does." Other comments from relatives included "[X] is not 100 per cent safe because of their balance, they have done a lot, every time I have asked they have put something in place" and "[X] had a bad fall a few months ago at night. They told me they had checked her but it happened in-between the checks."

Staff had a good understanding of how to identify safeguarding concerns and act on them to protect people. Staff told us "We protect vulnerable adults from potential abuse, including the development of pressure ulcers and falls. I would make sure the manager was aware and then investigate and raise a safeguarding alert, ensure the appropriate action was taken", "I would report concerns to the manager or care leader. If a person doesn't have verbal communication I look at their personality changes, if they were withdrawn, and check for any cuts or bruises", "It's about protecting people and their wellbeing and dignity and documenting anything and reporting it. I would go to the manager, I would trust her with anything" and "I would report to my manager. We have been given a leaflet for external reporting. If a person had no communication I would look for signs of fear, being withdrawn, any behaviour changes, if they stop eating and any physical evidence."

We found the service to be clean and staff were able to explain how standards of cleanliness were

maintained and cleaning schedules were in place to record that all areas of the home were being cleaned. The housekeeping staff were visible around the home and attended to any issues promptly. One staff member said "We deep clean people's rooms once a month and general clean every day. We have access to the necessary equipment now, the manager says get what you need. We are going to get a steam machine soon."

Requires Improvement

Is the service effective?

Our findings

At our last inspection in January 2016 the service was found to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.. This was because staff were providing care to one person who demonstrated physical and challenging behaviour towards staff during personal care support. Staff had been restraining this person during personal care and at times up to three members of staff would be present. An action plan was provided by the home which stated they would provide in house training for staff in this situation.

At this inspection no one was receiving this level of restraint from staff. However staff had still not received any training around behaviour management and were supporting people with high levels of behaviour that could challenge and at times required two members of staff. Staff comments included "Two staff go in for people with challenging behaviour, we are not holding anyone but we haven't had any training yet. It can be demanding and you need a lot of time with people" and "We have had no proper training on challenging behaviour, we discussed things on the care certificate and in induction. If you are calm and patient your in good stead, people are left to settle down, we stay away to leave them to calm down." We raised this again with the new manager and area operations manager who informed us that this absence of formal training in behaviour management had been raised by many staff in the trust. The manager said the care liaison team were coming in to give this training to staff as she had identified that people need this.

Staff gave mixed reviews about the training they had completed commenting "I have done a dementia course, fire training, you can do anything you want", "I have asked to do further training and started last month, the trust is very supportive", "Historically we have had very little management support regarding medicines administration. Practical updates in all skills are supposed to be assessed annually but never are", "I have done level my level two diploma which was supported here, I have done refresher training regularly and dementia training", "I haven't had much training" and "I haven't asked to do anything at the moment, I have been doing all my mandatory even when we had no manager."

A training record was in place which was in the process of being updated so the manager could establish that staff had received the training required. We saw that medicine competencies practical were done every two years and the theory part every year. However two people had not received this within the timeframes. The manger told us in light of previous concerns around medicines she would be looking to redo everyone's competencies. We identified gaps in some staff training which the manager had already picked up on. The manager told us she had spent time with a learning development advisor and identified who needed to complete what training.

Staff that had received a recent induction under the new management spoke positively about the support they had received commenting "The induction was really good, completed the care certificate. I was really impressed they covered everything" and "I did two to three weeks training, it was really good. I shadowed for two weeks that was brilliant, the girls were really supportive." However this had not been the experience for all staff during their induction. One staff told us they had not been assigned a 'buddy' staff member when starting because of staffing levels and was not observed properly to ensure they were competent in their

role. A second staff member told us they had been concerned that they were using equipment they had not received training for. Another staff told us "I had no support, it was a difficult few months, with the new manager it's improving massively."

We saw there was no recorded information in three staff files on any induction checks they had received and two people had not received their two month probationary review after starting at the home. One staff member told us when they had started they had not received any induction assessments or training around fire or manual handling. The manager had put an induction checklist in place, which included an induction around the home, time to look at people's care plans and understanding their roles and responsibilities. New starters would then shadow staff and have a mentor while they completed their care certificate (The Care Certificate aims to equip health and social care support workers with the knowledge and skills which they need to provide safe, compassionate care).

Staff one to one supervisions with their line manager had not been maintained consistently. One staff member told us communication was a "significant problem within the home" further saying "We have been here before. There has been no supervision, there are some staff meetings but no minutes are circulated for those who don't attend. There have been so many changes that it is hard to keep a constant, [X] (new manager) is receptive to change." Other staff comments included "I had one with the previous manager, but not had one since. I would go to the new manager if I had problems", "My last one was two weeks ago but before that it was a year ago", "My last one to one was with previous manager, I am due one" and "I had one about six months ago, I am due one, I have a supportive supervisor". We saw that one person had not received a supervision since 2014 and no annual appraisal since 2015. The manager had identified these gaps in staff supervisions and had implemented a supervision record to address this. In going forward staff would now receive four one to one supervisions called 'Trust in conversations' which would form part of their on-going development and be reviewed over the year.

This was a breach of Regulation 18 (2) (a) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that the home had not always completed or managed mental capacity assessments appropriately. For example one person had a capacity assessment in place for not being able to make themselves understood and communicate their needs or wishes. The assessment however did not detail what action had been decided on to help support this person. One capacity assessment had been completed to weigh a person monthly as they did not have capacity to agree to this. This had never been reviewed and there was no consent in place to support this. The manager explained this was done by the previous management team and should not be in place as the person was able to demonstrate if they were happy with care. Another person had a capacity assessment for staff to make the decision on 'What, when and where' the person would eat. This had been completed prior to the new manager and no consent or best interests discussions had taken place around this. This contradicted the person's nutritional care plan which stated the person could make their own choices of meals if they were shown visual choices and was able to point to the option they preferred. We talked to the manager about this level of restriction and she told us she was in the process of reviewing and removing these, as they had also concerned her that they had been put in place for these decisions without the involvement of anyone else.

We saw several capacity assessments completed by staff with no subsequent best interest meeting or discussion with anyone. The home had made isolated decisions for people who did not have capacity and then began to provide their care following the decision they had made themselves. One person had been noted as 'Lacking facial expressions' and unable to consent to living in the home and having medicines administered by staff. Consent had been signed by a relative who did not have the appropriate legal

authorisation to do this on the person's behalf. Another persons care plan stated 'If health declines will need support from family to make decisions on health, wellbeing and welfare but there was no Lasting Power of Attorney (LPA) in place for the family to make these decisions (LPA is a legal document that lets you appoint one or more people to help you make decisions or to make decisions on your behalf). One care plan stated it has been assessed that 'It is in person's best interests that they are assisted into bed before 10pm' but did not document how this decision had been made or by who. We saw some examples where consent had been obtained from the person and this had been clearly recorded in their care plan. However this was not consistent across all of the care plans we reviewed. The manager was aware capacity assessments needed to be reviewed and told us there should be the appropriate consent in place. This had been put on the manager's action plan and a day booked for the manager and head of care to review all the capacity assessment paperwork.

Staff we spoke with were able to explain how they took account of people's capacity when supporting them with care. Comments included "Whether they can make a decision or a choice themselves, I will always show them what I am doing and get choices of clothes out for them to choose" and "It's about someone's ability to make a decision until proven they can't, you presume they can. We support them, go in and offer choices around clothing and where to have breakfast". The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. The DoL 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. The manager told us that they were waiting for their submitted applications to be approved, however she planed to go through these applications again to ensure they remained relevant and add any updated information according to people's changing needs.

This was a breach of Regulation 11 (1) Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us the food offered was mostly ok and there was a choice or they would be offered an alternative. Comments included "There are choices but not always your choices", "Here it can be a bit dry though mostly it is the sort of food I might choose to eat. I don't like fruit so I'm not bothered if there isn't much, but the rest of the food is okay", "Some of the food is great while other things are not really me, but I don't say anything I just leave what I don't like" and I don't often get a choice as it is just one meat dish or vegetarian but the staff seem to know what I would like and bring it here. If I don't want it I can ask for something different." One relative said "My relative is enjoying the food more". Another relative said "The chef is excellent and knows residents very well, I have eaten the food on various occasions and it was very good."

Staff explained how they supported people around mealtimes saying "Some people choose to stay in their rooms, but we try and encourage them to always come down", "We make sure to go and speak to residents about the food", "We are getting things people need now, the new manager is on it, we have got adaptive cutlery and plates to empower people to eat how they want" and "Carers eat with people as it's much nicer to have someone eat with you than just to feed you." We observed staff going into people's bedrooms to offer them a choice of meals if they did not want to come to the dining room to eat. Cold juice machines were located around the home which contained hydration juice with vitamin C for people to help themselves. One area upstairs had been turned into a kitchenette where staff would serve breakfast from and people could make tea, coffee and toast throughout the day. Meals were taken upstairs pre-plated in a hot trolley. The manager and staff informed us that a new hot trolley was being ordered which meant meals could be plated upstairs instead.

The kitchen team knew people's dietary requirements and recorded any special diets, allergies or recommendations from the Speech and Language Therapy team (SALT). (SALT provide an assessment of swallowing or communication difficulties for people). Anyone in need of fortified foods and drinks were notified by a monthly audit sheet given to the kitchen with the plan for the next month or each person when another assessment would be made.

People's changing needs were monitored to make sure their health needs were responded to if there was a concern. One staff said "We report to the care leader, I always call them up to check people and they then decide to call a GP or not." We observed one staff member notifying the manager about a wound they had noticed on one person and then ringing an external healthcare professional to seek further advice. Relatives felt the home communicated well if their loved one was unwell commenting "If my relative had a fall or the GP came in they do tell me. They are very responsive to things like this", "He's had a few falls recently but there is good communication with the family and they always ring to let us know what is happening" and "The home has good communication over serious concerns but with family approval will leave minor communications until they come to visit rather than be continually phoning."

We observed that some areas of the home were starting to be decorated and updated. This had been planned at the last inspection but had not progressed. The manager had already made some positive changes such as putting the television into the smaller lounge so it did not have to be heard by everyone in the main lounge and dining areas. One room was being used as a 'hobby room' which afforded people a quieter space to spend time doing things they enjoyed. We saw one family using this room to hold a private birthday party for their loved one and staff had set the room up earlier for them. The manager told us "At the moment we are going to decorate the corridors, one has been done and this is the standard. We are then going to name the corridors with people, as it was meant to have happened previously and never did." We saw that people now had door knockers on their bedroom doors which made it appear more like their own front door. One relative said "The new manager has brightened up the place, there is new furniture."

Good

Is the service caring?

Our findings

People told us they were happy with the care they received commenting "The staff are very kind to me, they look after me well", "The staff are very good, I haven't been here long but the manager came and did a pre-assessment at the hospital before I was transferred to the home", "It's alright living here, there's good and bad like anywhere" and "They look after us so well and I have my hair done every so often too".

Throughout the inspection we observed many interactions between people and staff which were kind, patient and sensitive to the individual's needs. Staff responded to people in appropriate ways, bending down to their level to talk, not rushing people and explaining what they were doing. We saw one staff member supporting a person to change their position in bed so they could eat their meal comfortably. The staff told the person "We're going to have some soup" and put a napkin over their clothes explaining what they were doing. The staff sat and took their hand so they knew someone was there and encouraged the person to keep their eyes open and continued to have a conversation with them throughout their meal. One staff told us "It can be a wonderful environment, it's a hard job but very rewarding to make such a difference to peoples lives. Lots of staff have good relationships with people and have a laugh."

Relatives spoke positively of the care their loved one's received. One relative said their relative "Had been in the home for some time" and that "All the carers are very good but there are some including those from overseas who are outstanding." Another relative told us "He loathed the previous home he was in, but here he is let in and out promptly and he never feels he's on his own. The caring is kind and I like the way they try to coerce him with banter and humour which seems to work really well with him." Other comments from relatives included "Any carers I have talked to are interested and helpful", "The day staff are absolute gems", "Staff go out of their way to treat residents like family and other members of the family who visit are treated in the same way", "I cant speak highly enough of laundry, the way clothes are presented" and "Staff are caring I cant fault them."

We saw that people were offered choices around meal options. The chef was seen asking one person what they would like for breakfast and offered cereal. The person declined this and was then offered egg on toast with bacon to which they happily agreed. Another person was asked by a staff member "Would you like scrambled egg or boiled egg for a change?" Staff also told us "If someone is on a specialist diet they can still have choice and choose what ever they want", "If someone wants something different for breakfast we ask the kitchen so they can have what they want" and "Meal choice is done at the time, we always ask people even if some don't change what they want, we still ask." The manager told us the plan for the home was to be resident led, involving people in daily tasks such as housekeeping, and was hoping to purchase cordless hoovers for people to use and put cleaning buckets in place for those who wanted to participate in their own cleaning.

Each person had a keyworker which was a named member of staff that was responsible for ensuring people's care needs were met. Staff told us they valued the relationships they had built with people commenting "I love finding out about people's backgrounds, we have some amazing people here", "I love the residents, care is something you have got to love, I like chatting with them, I like helping them", "I love

working in this home, the staff and resident relationship is fantastic, it just needs the support it didn't have and now we can shine" and "Person centred care is about treating everyone as an individual, everyone is different, not using a blanket approach, there are different ways to support people".

Staff were able to tell us how they supported people whilst maintaining their privacy saying "I knock the door, cover person with a towel, draw the curtains. If anyone knocks on the door I inform them I'm doing personal care", "I shut the doors and windows. Some people have strong routines and they tell me in what order they like things" and "I knock the door and wait to be invited in to respect their dignity." We observed a few occasions where staff did not always uphold people's dignity by discussing people's personal care needs loudly in the corridors or with the office door open. On one of these occasions another staff member overheard and came to shut the door. One staff member was heard calling to another staff member "Is everyone done up there" when referring to supporting people with personal care. We fed this back to the manager to address.

Staff told us they encouraged people to maintain their independence saying "We get people to walk around as much as possible, so give a lot of encouragement", "If people can wash their face and hands we promote this, so they maintain it" and "We encourage people to walk and stand and give guidance." One external health and social care professional told us "The home is much more person centred. Staff are doing as instructed, but they feel empowered. For example one person was too unwell to use their assistive mobility equipment, staff recognised this and did not use it."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in January 2016 the service was found to be in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because monitoring records were not being correctly or consistently completed or managed. Care plans often contained conflicting information and made it hard to establish a person's most current needs. An action plan was provided by the home which stated they would address this without delay. At this inspection we found that the service had not taken the required actions needed to meet this Regulation and remain in breach.

One person was noted to have experienced a fall on 16 December and the care plans stated 'For Occupational therapist referral' but there was no record of this having happened or any instructions within the care plan reflecting external professionals guidance. For one person that had experienced a fall resulting in a bruise to the head there was also no record of observations that had been completed after this incident to safely monitor the person. The manager told us that normally 72 hour observations would be done but staff had previously been told not to record falls and incidents in people's care plans only in the daily records. The manager further said this was not how it should be recorded as needed to be reviewed. The manager confirmed this person would be referred to the falls clinic.

The recording of people's food intake and subsequent weights was not being managed appropriately. This meant there could be a delay in staff picking up any concerns and taking the necessary action to ensure people received effective care. Some people required their food intake to be monitored for specific concerns, however this was not being recorded on a designated form, instead staff used the same format that they used for daily records. The manager told us that the appropriate forms had been ordered. We observed staff completing food and fluid charts for people an hour after one meal had taken place and a staff member was recalling what up to 10 people had consumed whilst another staff recorded it. Some people's intake was very low but care plans did not always document that action had been taken. For example on one day a person did not eat breakfast, had three spoons of soup for lunch, and an angel delight and then declined their evening meal. Another day they had no breakfast, ate lunch and declined their evening meal. Another person ate only cornflakes for breakfast one day and their lunch and evening meal had just been left untouched in their room. One person had frequent days when they would be 'agitated and decline to eat'. For example on the 10 March they ate only faggots, on the 11 March they ate sweets overnight and a sandwich, the 12, 13 and 14 March they declined to eat. Staff had been recording weekly weights for this person and this had been stopped when their weight stabilised. This person's care plan did not identify any strategies or action to encourage this person with their eating.

One person had last been weighed in February and had lost 2.3kg since December 2016 but the recording had not been completed correctly. This person's Body mass index score (BMI), weight loss or risk had not been recorded (BMI is an attempt to quantify the amount of tissue mass and then categorize that person as underweight, normal weight, overweight, or obese). This made it hard to ascertain if there was a cause for concern and to monitor effectively. One person's care plan recorded on the person's likes and dislikes that they 'Didn't like potatoes' but no other preferences were recorded. People would have dietary plans for the chef to follow but these sat separate from people's eating and drinking care plans and the information did

not cross reference to give an accurate picture of each person's eating habits. Another person's care plan contained contradictions on how the person had their meals prepared. In July 2016 it stated the person had no teeth and required a soft diet. A month later in August 2016 it recorded the person could eat a normal diet. The care plan around nutrition was being reviewed, but like many of the care plans the reviews were dramatically different from the original care plan. One person had been on weekly weights as they were consistently losing weight. Their weights were recorded as -2.2kg, -0.8kg, -6kg, -2.6kg, +0.5kg, -6.3kg,+7.2kg which showed a lot of variation. On the last weight we saw that as soon as the person had experienced a weight gain the weekly recording of weights was discontinued despite this person having a record of consistently losing weight without looking at the full reasons behind this. We saw for one week it did suggest the weight scales were at fault but this had not appeared to have been followed up for this person.

One care plan for eating and drinking had no information recorded other than 'Ensure [X] receives a balanced diet and makes choices'. There was nothing around if the person could eat without support or what they enjoyed to eat. The dietary advice for the chef had not been completed, so there were no likes or dislikes documented. People requiring their fluid intake to be recorded were having this completed by staff, however there was no target intake volume and when people were recorded as drinking very low amounts, no actions had been recorded in response to this. One person was recorded on four consecutive days in March as having drunk 400mls, 300mls and 600mls. Another person had received 650mls, 250mls, 400mls and 700mls. We raised our concerns with the manager who was aware this had not been monitored and was implementing a system for senior staff to check these daily so concerns could be raised without delay. There was evidence in place that kitchen staff were aware of people's preferences, however important information concerning medicines and their diet had not always been relayed. For example three people were taking medicine that meant they should avoid any grapefruit products but the kitchen staff were not aware of this and it was not recorded in their care plans .

People who spent prolonged periods of time in bed and were at risk of pressure damage had been placed on repositioning charts. We saw that one person's chart recorded they required repositioning every four hours, however on two days they had gone for a period of six hours without any re-positing assistance whilst in bed. For another person on two hourly repositioning the recordings showed on three different days there were gaps of three and four hours. We saw that for people who had been prescribed topical medicines these were not always recorded to show the person had received them in line with the administering directions. For example five people who were meant to receive their prescribed cream daily had inconsistent recordings so it was unknown if they had received their medicine.

Care plans contained inconsistent information relating to how care should be provided and about people's needs. For example one personal care plan stated the person required assistance with all aspects of personal care from one staff, however 'Two staff would be needed for the lower half'. There was no explanation as to why this had been written and the manager was unable to provide clarification as this was written prior to her arrival. One person had two hospital transfer forms in their care plan which was used to share important information in the event a person needed to go into hospital to ensure their care remained consistent. The two forms gave conflicting information and it was unknown why there was two. One stated that the person only needed prompting with personal care, whilst the other stated they needed full support. One said the person was continent in their toilet needs, whilst the other stated the person needed pads for incontinence. The manager said these forms were going to be written at the time people were going into hospital but this would not have worked, so they will be reviewed and rewritten where necessary and then continued to be updated. Guidance was not always in place for staff to have the information to support people appropriately. For example one person had a catheter in situ but there was no information on how to provide care in line with this with. One person had a been diagnosed with a medical condition however this did not feed into the care plan despite the person needing support with managing this and looking out for

associated side effects.

Reviews had not been conducted on a regular basis. One person who should have received a six monthly review had a blank form in their care plan. One person's eating and drinking care plan was meant to be reviewed every three months but had not been reviewed in five months. This meant that staff could not be assured that he information in the care plans was up to date and reflective of peoples needs. We saw that the manager had already put a plan in place to review care plans on a six monthly basis. Staff told us they did not have time to read people's care plans and used the information in handovers to know about people's needs. One staff said "It's in the care plans about people's preferences but we haven't had time to read it, I would ask staff and get a handover." Another staff member told us "We are aware the care plans need to be more detailed, they need a lot of work to go into them. We need to show staff the standard they should be and support them." The manager had already identified care plans, and monitoring documentation needed a lot of work and had included this on her action plan to address. The manager told us they planned to finish people's life story books so this background information was in place, ensure staff recorded falls correctly and had planned for staff to receive documentation training.

This was a breach of Regulation 17 (2) (c) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in January 2016 the home had been recruiting for staff to provide activities to people. At this inspection we found the home had continued to struggle with maintaining activity staff but a new starter had been recruited and was in the process of starting their induction. Relatives voiced their concerns over the lack of available activities saying "My relative lacks stimulation, I don't know how many people sit and talk with her. People need more involvement" and "Activity staff are now in but I haven't seen that for weeks." We saw one person's activity care plan recorded they 'Stayed in their room and refuses to watch TV, staff to inform of activities happening' however there was no record of any activities this person had been involved in. Staff told us that people had not been able to access regular activities before the new manager came to the home commenting "People don't have enough. They have had activities but not whilst there hasn't been a manager, now there is an activities co-ordinator appointed, not since December 2016. People in their rooms don't get much interaction, they like their privacy", "Not enough to do, we have entertainers in, it would be nice to have daily activities for stimulation", and "Not at all do they have enough to do, people in their rooms have their TV but that's not great, some refuse to leave rooms and are happy."

During our inspection an arranged activity of a mobile petting farm came to visit the home including a horse, rabbits and sheep. People were supported to go outside and enjoy the animals, touching them and feeding them if they wished. Noticeboards were displayed around the home advertising events that were going to take place such as music fitness and the petting farm. The manager told us they had been outsourcing activities for people whilst they were recruiting staff so people still had things they could attend. One person told us "I choose to spend most of my time in my room; I just watch TV or do crosswords. I don't see the staff that much, only really when they need to do something." Another person said "I just like to sit and read a book or watch TV. I don't want to join in much it's my choice, I just want to stay in my room."

People's concerns and complaints were encouraged, investigated and responded to in good time. A complaints folder was in place with a log of all complaints received each month. We saw one complaint had been received in January and none since. At the time of the inspection there was not an easy read complaints process in place for people who may need information in this format. One relative said "Although I have never had to make a complaint or raise a concern I would be happy to do so knowing staff are very approachable." The manager told us "I am hoping as people and relatives get to know me they will come directly and raise things before it becomes a complaint." The manager told us she plans to implement

a 'grumbles' book to record any informal concerns and have a review book in the dining room so people can record thoughts on the food.

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager at the time of this inspection. The home had experienced a period of instability and this had impacted on people, their relatives and staff. This manager has been registered since we visited the service.

The concerns identified at this inspection had mostly historical roots and the manager was working hard to address these concerns, most of which she had already identified herself. An action plan was in place and people, their relatives and staff told us they had already seen improvements since this manager had been working with the home. Whilst we appreciate that the new manager had identified areas of concern, our last inspection was a year ago and the home had not made significant improvements in this time.

This was a breach of Regulation 17 (2) (a) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager was honest about the task she had ahead and was working hard to prioritise areas that required immediate attention and told us us "My vision is to have systems in place so if there was a change in management again it wouldn't set the home back, it would have robust systems in place already. I want to move forward with a person centred approach and be resident led." One of the management team told us "Myself and the manager are going to be a very supportive team to the staff, and in areas of developing the care plans, medicines, training and one to ones. Both myself and the manager have come from homes that have been resident driven and bring the community in to show people what the home is all about."

Staff spoke positively about the new manager commenting "The lack of a manager was hard, we have already seen improvements with the new manager, you can tell someone is leading", "The manger has been brilliant, such an easy person to talk to, I can email her and she responds straight away, she always handles things really well", "I have had a lot of managers and she's fantastic, she has the right temperament and has a good relationship with people and is approachable. There is so much she has to do from how its been left. The home just needs a bit of time to get structure on track", "I feel very well supported by management now, she's really on the ball and going to make a huge difference. I have seen happier residents, she interacts with them, she's a very positive person", "Every staff member is extremely happy that [X] is coming over, she deserves all the credit for the improvements" "The manager is approachable, puts a lot of dedication into the home. If you're unsure you can just go to her. I have witnessed her support the whole team and she's very hands on with residents" and "It's so much better in the last few months, morale was low, the manager has done amazing things already since she's been here, new furniture, TV put in quiet lounge, decoration plans. Morale has picked up, you can hear laughter again."

On an entrance noticeboard was a notice explaining to people and their relatives that the previous manager had left and who the new manager was alongside a photo to identify her by. One relative told us "The management have been responsive, now [X] is at the helm there has been such a difference when you walk in, the staff are a lot more happier." Other relatives comments included "Even in the short term the manager has brought things in" and "The manager appears to be everywhere not behind her desk all the time."

Staff told us they were now receiving more support and being updated on events through meetings. One of the management team explained "We are having a care meeting on Friday to speak with night staff and discuss how we want to shape the service and get their views about how they want to be supported. If we want a good service we need to support the team." We reviewed the minutes of one of these meetings and saw that the manager had explained what new things were being put in place and how time would be given to review care plans. It also recorded that in the sad event of a person's death, reflective meetings would be held for the staff to share how they will be feeling. Staff told us "I feel valued as an employee one hundred per cent", "We've had a lot of meetings and morale was low, we had a period without managers, the new manager promotes honesty with the staff and we can talk with her", "The staff are so passionate, they just want to improve" and "I love all the staff, we support each other." The manager told us she was keen to develop staff and had already signed 10 staff up to complete their level two diploma saying "They didn't feel empowered to progress, we are also looking at lead roles."

People and their relatives were being kept informed of changes relating to the service. The manager told us "Relatives have been positive about the improvements. A letter was sent to relatives about the management changes." We saw flowers were on display in the reception area which had been sent from a relative thanking the staff and home for the care of their loved one. The manager has planned a resident and relatives meeting and told us this would have a big focus on activities and finding out what people wanted to do.

Internal audits had identified shortfalls and an action plan was in place to address some of these areas of improvement. The operations manager had also been completing some audits on visits to the service. On coming to the home the manager started a fresh new audits and put a recording folder in place telling us that audits had not been previously analysed. The manager spoke about the importance of sharing this information with staff and we saw a 'How we are doing' board displayed in the care office. This meant that staff were able to see information on areas of falls, infections, weights, care plan reviews and supervisions so they could be part of the monitoring process and understand the importance of recording correctly and what this information is used for.

Incident and accident reports were kept in people's files but the manager had also started to keep a central folder of them for monitoring purposes. The manager told us if someone had a fall, a falls analysis should be completed, in the 'Aim to prevent falls not react to them'. The manager had started a matrix in January on falls to monitor these, prior to this information on falls had all been kept separately and had been hard to locate. Incidents were looked at to see why they occurred and how they could be prevented. The manager told us "The head of care has worked on the information staff record in incident reports and they have improved. The more information we get the more we measures we can put in place. The environmental audit now sat alongside the falls audit so any potential contributory factors could be eliminated.

The manager had identified from a call bells analysis, that people's waiting times appeared high. The manager said this was due to staff not being able to always hear the bells when they were in bedrooms so pagers were purchased for staff to carry on them and in February the manager noticed a decrease in these waiting times. The manager completed a night spot check recently and planed to do this on a more regular basis to ensure things were running as they should. The manager checked that calls bells were in reach, drinks were in reach, sensor mats were plugged in, repositioning was taking place and security checks. This visit had not been recorded as it was also an opportunity for the new manager to meet the team but will in future will document these.

The manager told us she had been well supported since managing The Cedars and within the company saying "There are lots of opportunities for me, it's a nice company, the support is there to progress. There is

always extra training. My support has been brilliant, we hold weekly project meetings and senior management are always on the phone. Anything I have asked for has been put in place". The assistant operations director and area operations manager had been overseeing the home in the absence of a permanent manager and planned to continue to visit monthly or more and support the home and manager.

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 11 HSCA RA Regulations 2014 Need for consent We saw that the home had not always completed or managed mental capacity assessments appropriately. Regulation 11 (1)

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 Risk assessments had not always been reviewed within the designated timeframes to ensure they remained in line with people's changing needs. We saw some examples where risk assessments had not been put in place or contained inconsistent information about a person. Regulation 12 (2) (a) The home did not have effective measures in place to be consistent in their management of behaviours that challenged. Regulation 12 (2) (b)

The enforcement action we took:

Impose a positive condition on the registration of this location. The home will submit a report monthly to ensure that records are being monitored, audited and updated as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Monitoring records were not being correctly or consistently completed or managed. Care plans often contained conflicting information and made it hard to establish a person's most current needs. Regulation 17 (2) (c) The home had not made significant improvements since our last inspection where we identified areas of concern. Regulation 17 (2) (a)

The enforcement action we took:

Impose a positive condition on the registration of this location. The home will submit a report monthly to ensure that records are being monitored, audited and updated as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing During the inspection we observed that there were not sufficient staff to respond to peoples needs in

a timely way. Staff consistently told us how the home did not have the right levels of staff. Regulation 18 (1)

Staff had not always received the appropriate training, induction support or regular one to one supervisions with a line manager. Regulation 18 (2) (a)

The enforcement action we took:

Impose a positive condition on the registration of this location. The home will submit a report monthly to ensure that staffing, training and supervisions are maintained in order to provide safe and effective care.