

# 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?

**Requires Improvement** 

Is the service responsive?

**Requires Improvement** 

Is the service well-led?

**Inadequate** 

# Summary of findings

## Overall summary

The Cedars is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service can provide accommodation and personal care for up to 49 older people at this location. At the time of our inspection there were 39 people living in the home, however three of these people were in hospital. The inspection took place on 6 and 15 March 2018 and was unannounced.

At the inspection on January 2016 we asked the provider to take action in response to our findings. A planned inspection took place in March 2017 to follow up on the concerns found at the previous visit. At this visit the service received a further rating of requires improvement and where we found breaches of three Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to risk assessments not in place or reviewed within designated timeframes. There was ineffective management of people's behaviours that challenged and insufficient staff to respond to people's needs. Records were not monitored correctly or accurately completed.

We took enforcement action against the provider and imposed a positive condition on the registration of this location. The service submitted a monthly improvement report to ensure that staffing, training and records are being monitored, audited and maintained in order to provide safe and effective care. However the action plan was not always consistent with the findings we found at this inspection.

At this inspection we found that the service had met one of the previous breaches identified and part of another breach. The service remained in breach of three Regulations, and were in further breach of other Regulations. This is the third consecutive time that this service has been rated as requires improvement and we are considering what further action will be taken in response. We met with this provider to discuss these concerns and seek assurance about the action they would take. The positive condition imposed on the registration for this location will remain in place until we re-inspect again shortly.

The registered manager was absent from the service and on a period of planned leave. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The head of care had stepped up into the role of acting manager since February 2018 and was going through the process to become a jointly registered manager for this period of time. The acting manager and area operations manager were both present and available throughout our inspection.

Medicines were not always managed safely. People with prescribed time specific medicines did not always receive these on time. Stock levels of some medicines were not regularly checked. The service was in breach of this Regulation.

Risk assessments did not always contain enough detail to minimise the risk. Examples of unsafe practice were observed. The recording of people's behaviour that at times challenged was not consistent or appropriate. The service remains in breach of this Regulation.

Although the levels of staffing were sufficient according to the provider's dependency tool, the deployment of staff was not always managed efficiently. The service remains in breach of this Regulation.

We observed interactions where staff did not always act respectfully in regard to the people they supported or maintained their dignity. The service was in breach of this Regulation.

The service continued to have ineffective recording in care plans and monitoring records. The lack of appropriate recording meant that risks to people may not be identified in a timely manner. The service had remained in breach of this Regulation.

Quality assurance systems were in place. Despite identifying some of the same concerns we found during this inspection, action was not always taken in response to these. There was a lack of robust monitoring for documentation. Governance systems had not improved or were effectively maintained. Areas of concerns identified were not addressed to ensure people receive safe and caring treatment from staff. The service remains in breach of this Regulation.

People's experience of care was assessed through feedback opportunities. We saw where comments had been made by people these were considered and actions discussed.

Some improvement had been made around mental capacity documentation, however consent to care had not always been sought in line with legislation.

Staff were not consistently supported to have regular supervisions with their line manager.

People were positive about the activities provided in the home; however we observed at times a lack of understanding from staff about how to provide activities for people with dementia.

People and their relatives were positive about the care they and their family member received. People told us they were involved in making daily decisions about their care such as when they preferred to get up, go to bed and preference on the gender of staff to support them.

Improvements had been made to the training and the recording of the induction staff received.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not always safe.

Medicines were not always managed safely. People with prescribed time specific medicines did not always receive them on time. Stock levels of some medicines were not regularly checked.

Risk assessments did not always contain enough detail on how to minimise the risk. Examples of unsafe practice were observed.

Although the levels of staffing were sufficient according to the provider's dependency tool, the deployment of staff was not always managed efficiently.

The service followed safe recruitment practices. Records showed that the appropriate character checks for new staff had been made.

**Requires Improvement** ●

### Is the service effective?

The service was not always effective.

Staff had still not always been supported to have regular supervisions with their line manager.

Improvements had been made to the training and the recording of the induction staff received.

Some improvement had been made around mental capacity documentation, however consent to care had not always been sought in line with legislation.

**Requires Improvement** ●

### Is the service caring?

The service was not always caring.

We observed interactions where staff did not always act respectfully in regard to the people they supported or maintained their dignity.

People and their relatives gave positive comments about the

**Requires Improvement** ●

care they and their family member received.

### **Is the service responsive?**

The service was not always responsive.

The service continued to have ineffective recording in care plans and monitoring records. The lack of appropriate recording meant that risks to people may not be identified in a timely manner.

People were positive about the activities provided in the home; however we observed at times a lack of understanding from staff about how to provide activities for people with dementia.

People's concerns and complaints continued to be investigated and were responded to in a timely manner.

**Requires Improvement** ●

### **Is the service well-led?**

The service was not well-led.

Quality assurance systems were in place, however despite identifying some of the concerns we found during this inspection, action had not always been taken to address these.

There was a lack of robust monitoring for documentation. These records were not completed appropriately and there was no evidence that the issues had been identified and raised with senior management.

The governance of this service has not improved or effectively maintained in order to address the areas of concern and to ensure people were receiving a safe and caring service.

People's experience of care was assessed through feedback opportunities. We saw where comments made by people were considered and actions discussed.

**Inadequate** ●

# 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 was a planned inspection to follow up on the concerns found at our last inspection in March 2017. At our last inspection this service received a rating of requires improvement and three breaches of the regulations were identified. This is the third consecutive time that this service has been rated as requires improvement. We met with this provider to discuss these concerns and seek assurance about the action they would take. A positive condition was imposed on the provider's registration for this location and this will remain in place until we re-inspect again shortly.

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.

This inspection took place on 6 and 15 March 2018 and was unannounced. The inspection team consisted of two inspectors 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.

During our inspection we spoke with twelve people living at the home, six relatives' visitors and, two health and social care professionals. We also spoke with, the acting manager, area operations manager and seven staff. We reviewed records relating to people's care and other records relating to the management of the home. These included the care records for seven people, medicine administration records (MAR), eight staff files, the provider's policies and a selection of other records relating to the management of the home. We observed care and support in the communal lounge and dining areas during the day.

# Is the service safe?

## Our findings

Medicines were not always managed safely. Although medicine administration records (MAR) we looked at were signed to indicate staff had administered medicines as prescribed, people did not always receive their medicines on time. Some people were prescribed with time sensitive medicines for their health conditions. These medicines must be administered as prescribed for maximum efficiency as their abortion may be compromised. For example, three people were due medicines at 12.00pm. We observed that one person received theirs at 12.30pm and another at 12.35pm. The staff member administering the medicines said they had given the previous dose 20 minutes late but this had not been documented on the MAR. Two other staff members said the registered manager had purchased a pocket alarm for staff to use as reminders about time sensitive medicines. We saw this alarm was not being used by the staff. This meant it was unclear how staff were ensuring that people received their medicines at the times prescribed. This had also been raised during our previous inspection.

Stock levels of some medicines were not regularly checked which meant that people may not have their medicines available in stock for when they were needed. This meant that staff were not aware of the medicines in stock or missing. Prior to this inspection we were aware of an occasion where one person did not receive their medicine for a period of two days. It had not been identified in time that this medicine was due to run out until the day the last tablet had been given. The service took action in response to this error and implemented measures to reduce a reoccurrence of this incident.

Medicines were stored securely. Although stock balances of medicines that needed extra security were being carried out, the documentation associated with this was poor. One entry for a person's medicine stated that there were three in stock. In the next entry staff had written ten in stock, but there was nothing documented to say where the other seven had come from. We undertook a stock check of this medicine with a member of staff and there were ten in stock. The increase in stock when new medicine had been delivered by the pharmacist had not been signed in and recorded. The stock levels are checked daily by staff but this had not been picked up during these daily checks. This meant there was not a robust system being used of checking the correct stock level of this medicine. Additionally, the monthly medicines audit had not identified this issue. We raised this with the acting and area operations manager during our inspection. The acting manager told us "Medicines is still an area we need to look at, we are working in partnership with a clinical pharmacist around this."

Some people had been prescribed additional medicines on an as required (PRN) basis. Protocols were in place to inform staff when and why people might require these. In the main, these were person centred. For example, pain relief protocols explained where people tended to experience pain and the reasons why. However, protocols for the use of anti-anxiety medicines did not always specify how people presented when anxious and did not detail the steps staff should take before resorting to the use of medicines. For example, in the protocol for one person, staff had documented "to help relieve anxiety for [person's name] to be able to let staff give assistance with personal care and for his behaviours to be settled". This meant guidance was not detailed on when to administer medicines to reduce anxiety and allow staff to deliver personal care.

Topical medicine administration charts had not been completed in full. Although there were shaded body maps and clear instructions for staff to follow, staff had not always signed to indicate that creams and lotions had been applied. For example, one person had been prescribed a barrier cream to be applied three times daily due to incontinence. The chart had been signed by staff only once daily in the three days prior to our inspection and not signed at all on another day. Another person had been prescribed a cream to be applied twice a day, but staff had only signed once a day on two days and not signed at all on another. This meant there was a risk that people did not always have creams and lotions applied as prescribed.

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

We observed part of a medicines round. The staff member asked people if they needed any pain relief, ensured they had a drink and checked people had swallowed their medicines before signing for them. People's preferences in relation to how they liked to take their medicines had been documented. There were photographs of people at the front of the MARs to assist staff to identify people. The temperature of the clinical room and the medicines fridge was monitored and showed that medicines were stored at safe temperatures.

At our last inspection in March 2017 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 risk assessments were not always in place or reviewed within the provider set timeframes. The service did not have effective measures in place to be consistent in their management of people's behaviours that challenged. A monthly improvement report has been submitted since this inspection to show the progress of meeting these concerns. The provider stated in the monthly report for 28 February 2018 that the service had been meeting all of these concerns since November 2017.

At this inspection we found that the service had not taken the required actions needed to meet this Regulation and remained in breach for the second consecutive time.

Care plans contained risk assessments for areas such as falls, mobility, skin integrity and nutrition. When risks had been identified, the plans provided some guidance for staff on how to reduce these. For example, when people had been assessed as having a high risk of developing pressure sores, the plans detailed pressure relieving equipment that was in use and the required frequency of position changes. However, the level of detail was not always comprehensive. For example, when air mattresses were in use, the plans did not specify the required settings. When asked, one staff member said they didn't know how to check if the mattress was set correctly. Repositioning charts had a section for this detail however this had not been specified. Although no one had experienced a pressure ulcer in relation to this, there was an increased risk due to ineffective knowledge and recording. We raised this with the management who took timely action by contacting the mattress supplier for information on checking the settings. This was then updated into people's care plans."

We reviewed the documentation in place for people who were supported to regularly change their position to prevent pressure sores. However we saw that these were not always completed in line with the support people should receive. For example one person required their position to be changed every four hours during the day and night. We saw on four days in February there were gaps of five and six hours where this person was not supported in the appropriate timeframes. There was no information on why this had happened or if this had been identified and raised further. Another person should have had their position changed every four hours, but the care plan specified "two hourly when in chair and four hourly at night." The recording on this person's positional chart ranged from one hour to seven hours. This meant there was

a risk that people were being placed at a higher risk of developing pressure sores because they were not having their positions changed as frequently as they should. We informed the acting manager who was unaware of these gaps.

Fire risk assessment tools were in place. However, there was limited detail to inform staff on how to support people in the event of an evacuation due to fire. For example, in one assessment staff had documented "Has dementia, so would require evacuation aids." There was nothing written to inform staff what aids were needed.

During our inspection we saw examples of unsafe practice. One person who was at high risk of falls and had a sensor mat in place to alert staff if this person got out of bed so they could support them safely. However we observed that whilst this person was in bed the sensor mat was pushed under their bed and was not plugged in. We spoke with a staff member who confirmed this person needed their sensor mat in place when in bed and went to address this.

Another person who was at high risk of falls and had experienced several recent falls with injuries was shouting out in their bedroom. We asked this person if they needed some staff support which they replied they did. We pressed their sensor mat as their call bell could not be located but no alarm sounded. The person was increasingly distressed. We saw that their sensor mat had not been plugged in. We pressed the call bell once it was located across the room on a chest of drawers and out of the person's reach. We waited for over four minutes for a staff member to come and attend to this person and we explained the sensor mat had not plugged in. This meant people already at high risk of falls were at further risk of not being supported when they mobilised and not receiving support in a timely manner if they did fall.

Records showed that people were experiencing high levels of falls in the home with 27 falls documented in January 2018. We saw from a falls lead meeting held in February 2018 that there had been a 1,000 falls across the provider's homes monthly and that this would be addressed through looking at the structure of shifts, handover times and sensor beams.

We saw one person's walking frame had been stored in an unsafe position balanced on top of their wardrobe. We asked staff to immediately remove this to ensure the risk of this falling and injuring this person was prevented. This was raised with the management team. One person who at times displayed physically aggressive behaviour had thrown some crockery that morning which had broken. We saw that staff had left the broken pieces on a table outside this person's room instead of moving it away from this person and other people in the home. We asked staff to remove this to prevent a further risk and saw they then left it on a tray in the upstairs satellite kitchen, which was still accessible to people. We raised this a further time and informed management of this event.

There was confusion from staff around visual checks being made to people who were unable to use their call bell if they needed support. One staff member said there were visual checks in place but these were not always recorded in the daily records and they recorded them on people's repositioning charts. Another staff said no visual checks were in place for anyone in the home. We checked the daily records however and saw that during February staff were recoding that some people had received their two hourly checks. This meant there was a risk of staff not being consistent in checking people who may be unable to call for support.

We observed that several hoists used to help people transfer were left in people's bedrooms despite the service having created hoist stores after this was previously raised. The acting manager informed us that some people had their own hoist and this was kept in their room and the other hoists should be stored away. We reviewed the health and safety meeting minutes from January 2018, which reminded staff that

equipment was to be stored downstairs and not left in communal areas.

We saw that when some people became anxious or frustrated their behaviours were difficult to manage by staff and placed other people at risk of harm. For these events staff recorded the behaviours on a chart and the action that had been taken to diffuse this incident. However the recording of these events was not always appropriate and demonstrated a lack of understanding in managing these behaviours. For example on person's behaviour incident form stated that the outcome was for staff to make coffee and biscuits. The staff had recorded. "I have not been back to see [X]." Another incident documented that a staff raised their voice and told a person to 'Stop this and sit in your chair.' The word 'diffuse' was often recorded by staff in describing the action they took but there were no details on what was meant by 'diffuse' in order to assess if their method had worked and to remain consistent in the management of this.

Although we saw that external professionals had been contacted to support people's behaviour the provider had not reviewed the behaviour strategies staff were using. There was no clear guidance for staff to follow that was specific to support each individual. The acting manager told us that a new admiral nurse was supporting through visits and phone calls and that 75 percent of staff had now received 'Distress Reaction Training'.

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

There was clear documented evidence to show when health and safety checks including water quality testing, sling checks and fire extinguishers had been carried out. The acting manager had put notices in place to ensure that people, their relatives and staff were aware of the recent extreme weather conditions and action had been taken to ensure people continued to receive their care.

At our last inspection in March 2017 the service was found to be in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was not always sufficient staff to respond to people's needs in a timely way. A monthly improvement report has been submitted since this inspection to show the progress of meeting these concerns. The provider stated in the monthly report for 28 February 2018 that the service had been meeting all of these concerns since August 2017.

At this inspection we found that the service had not taken the required actions needed to meet this Regulation and remained in breach for the second consecutive time.

Although the levels of staffing were sufficient according to the provider's dependency tool, the deployment of staff was not always managed efficiently. Call bells were not always answered swiftly and at times it was difficult to locate a member of staff. On one occasion we observed one person tell a non-care member of staff they needed to use the toilet. The staff member went to inform the care staff. We observed the person waited for approximately 20 minutes before a staff member came to assist them. This meant the person was not able to control their continence needs.

On another occasion we supported a person who needed a member of staff and helped raised the alarm for them. We waited with this person for over four minutes before a staff member came during which time the person became increasingly distressed.

People said that on most occasions bells were answered reasonably quickly. Two people said that there

were times when staff were very busy and they had experienced some waits. Staff told us "I think there is not enough staff at moment, we cope well, need a definite increase", "People's needs have changed a lot, staff all prefer to have more time and we make the time", "We all went through a time where people's needs are high and needed two carers. Now we just focus and get a routine" and "To have more time with the residents would be nice, but it's a busy home." We reviewed a call bell audit to see how timely staff were in responding to these. It showed the peak times for call bells taking over five minutes to be answered were in the afternoon and could show a link to when staff had their handover. The acting manager said one staff was allocated to answer call bells during handover.

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

A hostess member of staff was on duty in the dining room to assist people with drinks, serve meals and clear and lay the tables. The acting manager told us the staffing had improved across all departments and they were currently looking into the structure of staff shifts. A dependency tool to calculate staffing levels was in place and updated monthly or when anything changed. The acting manager told us "We look at recruitment on a regular basis. We are working with staff about the deployment and this will be addressed." The management team spoke about an online system that was going to be developed in the home enabling staff to sign in and would improve deployment by freeing up staff time to other things.

The service followed safe recruitment practices. Staff files included application forms and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. Records seen confirmed that staff members were entitled to work in the UK.

People we spoke with told us they had no concerns about their own safety commenting "It's a nice place; it's safe alright because people listen to me", "No worries at all. All very good here. The building is secure and I have never had a problem with things in my room" and "It's safe, no troubles, staff are about if I had a problem." One relative said "Fed, happy and she is safe. If not happy things are addressed through carers. Things are dealt with quickly."

We observed staff supporting people with their mobility and saw the correct practice was followed. Comments from people included "Staff definitely know what they are doing", "I need a lift [hoist] to get me up. Girls [and boys] very good, they know all about what they are doing" and "I have to use one of these things [walker] to get about. Staff keep an eye on me but never tell me not to go where I want." One health and social care professional told us "I have confidence in the staff I have spoken to and worked with. They had a very good knowledge of the residents I was reviewing."

Staff had access to information about safeguarding and how to help keep people safe. One staff told us "We make sure people are safe and free from harm and abuse, we would report it to the manager, CQC and the Local Authority." The area operations manager told us they gave people space to make them feel comfortable to raise concerns instead of putting the spotlight on them. People were encouraged to raise things as they happened and had been given handbooks with safeguarding information in.

We found the home to be kept clean and mostly free from odours. We did observe an odour in one corridor of the upstairs part of the home which remained throughout the day. Housekeeping staff followed cleaning schedules and correct hygiene practice. These practices included wearing gloves and aprons and using the correct colour coded cloths, buckets and mops to reduce the risk of cross contamination between high and low risk areas. One person told us "It's very, clean. The cleaners are in every day." A relative said "Very

impressed [with The Cedars] we looked at 10 care homes before deciding on this one. Good feel, clean and tidy. Nice staff."

## Is the service effective?

### Our findings

At our last inspection in March 2017 the home had been in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff had not always received the appropriate training, induction support or regular one to one supervisions with a line manager. A monthly improvement report has been submitted since this inspection to show the progress of meeting these concerns. At this inspection although we saw that further improvements were still needed around staff supervisions, enough action had been taken to meet this part of the regulation.

Staff were not consistently supported to have regular supervisions with their line manager. These were known as 'Trust in conversations' and should have taken place on a six monthly basis. We saw large gaps between some staff receiving these. One staff had gaps of 13 months between their supervisions. Another staff had gaps of over a year and another staff a gap of nine months. We raised this with the acting manager and the area operations manager who also checked some staff supervisions at random. One staff had received five supervisions in seven months; however a further two staff were found to have gaps of one year. The management were unable to explain why these had not been taking place. The acting manager told us since they had stepped up they had put a supervision matrix in place and had completed 33 staff supervisions so far. We saw in the minutes of a staff meeting in August 2017 it recorded that trust conversations were way off target and needed to be improved.

Staff told us they had the training and skills they needed to meet people's needs and were supported to refresh their training. Comments included, "I have completed fire safety over at another home, I can do moving and handling, can also choose training outside of my job role" and "I want to do end of life training so I have asked for this. I am going to do manual handling assessor training. We need to know this part of the job. The induction was intense but once I got into the home it made sense."

A training matrix was in place which indicated when training was in date and due to expire. We observed some gaps on the training matrix but action was in progress to address this and training dates booked. The provider's learning development advisor visited monthly and would set a training action plan for the home. The acting manager told us they were looking at providing evening training sessions for night staff, to give them the same opportunities to complete relevant training for their role.

At our last inspection in March 2017 the home had been in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because mental capacity assessments were not always completed or appropriately managed. A monthly improvement report has been submitted since this inspection to show the progress of meeting these concerns. At this inspection although we saw that further improvements were still needed around consent to care, enough action had been taken to meet this Regulation.

The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other

professionals, where relevant. The Deprivation of Liberty Safeguards (DoLS) are part of the Act. 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 home has two people who had an approved DoLS in place and more that had been applied for.

We saw that consent to care had not always been sought in line with legislation. Some people had sensor mats in place to alert staff if they tried to stand up or walk. In one person's sleeping plan staff had written "has an alarm mat in place due to history of falls" but there was nothing documented to show that staff had assessed the person's capacity to consent to this. Another person had no mention of their sensor mat in their DoLS application, despite it being a restriction they had been unable to consent to.

One person was having their medicines administered covertly. This is when medicines are "disguised" in food or drink. The person's capacity to consent to this had been assessed. A best interest decision meeting had taken place and this was clearly documented. The records showed involvement of the GP and the pharmacist. However, the form was dated 27 September 2017 and it had been documented it was for a "two week trial." There was no evidence of the decision having been reviewed at the end of the two week period and no evidence of the decision being reviewed since.

The acting manager was keen to employ technology in gaining better insight to information. For example they had looked into the call bell analysis data and worked to alter the format of the information into graphical displays. This would allow for patterns to be identified and specific actions to be taken in response. The area operations manager told us "We can identify what call bells relate to falls; we can get a better understanding and drill down to see if we need further support at these times. We can do observations and make recommendations."

Information on dementia was displayed on a noticeboard for people and staff to access and one staff had taken the role of a dementia lead in the home. The acting manager told us they were trying to arrange for this person to undertake further training in this area.

People told us that they had enough to eat and drink. They said that the quality of the food was good commenting "Very good food, choice of two mains and various puddings. Change of chef, so food better now", "Plenty of drinks during the day, even alcohol at lunch, beer, sherry" and "Not too keen on some things so the chef knows to do me something else like soup or an omelette." People had access to drinks in their rooms, from drink stations around the home and staff were seen encouraging people with drinks in communal areas.

We observed that mealtimes were a social occasion. People enjoyed chatting to staff and friends and were able to make their choice of meal at the point of service. For people that needed support from staff to eat their meal this was conducted at the pace of the person and staff waited until the person had finished before offering more. Food temperatures were checked at the point of service, from the kitchen on the ground floor and on the hot trolley on the upper floor.

People's nutritional needs had been assessed. People with their agreement had their weight monitored. When people had lost weight, guidance and support was sought. Records showed people had been reviewed by the speech and language therapist (SALT) and had provided advice on textured diets and thickened fluids. Care plans detailed the positions people needed to be in when eating or drinking to reduce the risk of choking.

People had access to on-going healthcare. Records we looked at showed people had been reviewed by professionals including the GP, the mental health team, admiral nurses, and the chiropodist. When people felt ill, or when staff noted an issue of concern, records showed that GP or district nurse advice was sought swiftly. One person said "I see the GP when I need one, I only have to ask." We asked one health and social care professional if the home was good at working and sharing information with them and they replied "Excellent."

Where people may need to transfer from The Cedars into another setting for medical or other care and treatment we saw information passports were in place. These contained essential information and things the person may want professionals to know about them in order to meet their needs. We saw one person's passport did not include essential information about their tendency to display certain behaviours which placed a risk to others. The acting manager said this would be addressed

The home had spent time considering the environment for people. There was pictorial signage and the differentiated wall colours helped people to orientate themselves around the building. The corridors had been named with a street sign and people's doors were numbered and had knockers to represent their private address. The grounds were accessible with paved paths and free from trip hazards. People told us they enjoyed using the outdoor areas when the weather was suitable with one person commenting "I like to go out in the garden area when it's nice, it's lovely out there."

## Is the service caring?

### Our findings

The atmosphere of the home was pleasant and friendly and although we saw some positive interactions between people and staff, this was not consistently seen. On several occasions we observed staff walk through the main lounge and dining areas without engaging with people who were sat at tables or in armchairs. One person frequently called out to staff for help. Although staff said the person did this throughout the day, not all staff spoke or offered reassurance for this repetitive behaviour. Some staff ignored them completely.

One person had asked staff to support them with going to the toilet. Staff told this person they would be back shortly; however they failed to return for some time or asked another staff to assist. While this person was in the lounge they were unable to control their continence needs which comprised their dignity. We observed when a member of staff eventually arrived this person was not taken directly to their bedroom. This member of staff stopped in the corridor to speak to other staff although this person was sat in the wheelchair needing assistance with personal care. This showed a lack of respect for the person and did not demonstrate that staff always respected and upheld people's dignity.

We observed one person walking up and down in the reception area appearing anxious and distressed. A staff member was standing by the front door and told the person "Come and sit down and wait for the taxi to [name of town]." The person continued to walk around and look out of the door glass and continued to talk about going back to their town in a distressed manner. The staff said again "You can't get back to [name of town] without the taxi, sit down and have a nice cup of tea before we go, you're alright, just get your coat." The person then headed off after this instruction towards their bedroom. Another person then said to the staff "What's wrong with her" and the staff replied "You just have to ignore her." We asked the member of staff if this person was going to [name of town] and she told us "No, we just tell her that as she always asks. We say go and get your coat and then by the time she gets to her room she forgets it." This meant staff were not acting appropriately towards this person or treating them in a dignified manner. We raised our concerns around this upsetting incident with the management team to address.

We observed other interactions where staff did not always act respectfully in regard to the people they supported. For example when discussing about which people had been supported with personal care, one staff remarked "I have done him." Another person needed their meal cut into small bite size pieces to prevent risk of choking. We saw a staff member take the person's meal to them and then stand over them to cut up their food up at the table. This could have been prepared before the meal was served to promote this person's dignity, rather than in front of everyone.

This was a breach of Regulation 10 (1) Dignity and respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On other occasions we saw that staff did attempt to maintain people's dignity. One person had chosen not to get fully dressed despite sitting in the lounge area and on several occasions we observed staff encouraging the person to keep a blanket over their legs to maintain their dignity.

On other occasions we saw staff speaking kindly to people by crouching down to their level to make eye contact.

People told us they were happy with the care they received. Comments included "Carers are quite alright, friendly staff", "I get on very well with the carers. Even one who has left still comes back to visit me", "Nice carers, not much to grumble about" and "Carers look after me very well." We observed staff showing compassion and kindness in some interactions and used their knowledge of people to offer personalised care. One staff spoke about how they needed to provide reassurance to one particular person through regular visits and the way they liked to be approached saying, "We know our residents. We try as much as possible to surpass any previous bad memories." Another staff told us "I love the residents, to see the smile on their face, I love my job."

Relatives we spoke with felt happy with the care their family member received commenting "'Carers are lovely. Can't fault any of them, they all love mum", "The general care is better than last year", "Always very good care. [X] was very depressed at home. Now nice to know she is interacting with people and making friends. Staff very kind to her" and "Most carers are absolutely brilliant." One health and social care professional told us "I believe the staff do listen to the residents, they are very caring and give opportunity for residents to express their views and choices. I have had concerns in the past that there is too few staff on duty but this seems to have been resolved now."

The acting manager told us that they monitored the care people received by asking for feedback, listening to people and carrying out observations, which were not currently being documented. The acting manager commented "It is about reflective practice, learning from mistakes and looking at how to develop. We involve the resident about their care and the Qualifications and Credit Framework (QCF) assessors do a lot of observations and feed back to us" (QCF assessors support and assess staff working towards vocational qualifications to meet the right standards).

People told us they were involved in making daily decisions about their care such as when they preferred to get up, go to bed and preference for which gender staff they had. People told us "I choose when I get up or go to bed"; "I am asked if I would like to join in with the activities, can choose too or not" and "Always asked if you would like woman or man carers." The acting manager was in the process of purchasing ornaments and decorations for the home and told us people were involved in making the decisions around this. The acting manager commented "I don't want us to go out and buy things for residents, we involve them. I take pictures and they vote what they want. We are doing it with table flower decorations and then buy the ones they want."

The acting manager told us people's human rights and diversity were considered and encompassed into their care. New documentation was due to be implemented by the provider which looked deeper into people's culture and sexual preferences and the effects this had on their later life and care wishes. The acting manager told us it was important not just to explore this at admission but to have on-going conversations with people. Within the home there was a diverse team of staff who had returned from retirement, younger generations, staff from different countries and other staff completing voluntary or work experience in the home.

## Is the service responsive?

### Our findings

At our 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 and care plans were not being correctly or consistently completed or well managed. At our last inspection in March 2017 the service had not taken the required actions needed to meet this Regulation and had remained in breach. A monthly improvement report has been submitted since this inspection to show the progress of meeting these concerns. The provider stated in the monthly report for 28 February 2018 that the service had been meeting all of these concerns since January 2018.

At this inspection we found that the service had not taken the required actions needed to meet this Regulation and remained in breach for the third consecutive time.

Documentation did not provide sufficient detail to establish that people's on-going needs were being met. Some people living in the home were at risk of malnutrition, dehydration or pressure sores and this risk was managed through monitoring records. Staff recorded information on the monitoring charts to track if the risks increased, so early intervention could be taken where needed. We reviewed people's food and fluid monitoring charts and saw these had not always been completed fully. Food charts detailed the type of food people had been given and how much they had eaten, but this was limited to "ate half" or "quarter eaten" for example. Staff had not specified exactly what people had eaten, the amount given to the person and if this was usual for that person.

Care plans were not always up dated according to people's changing needs. We saw one person regularly declined their meals. This person had lost a significant amount of weight from November 2017 to February 2018 totalling 20.4kg. A review completed in March stated this person would only eat and drink when they wished and that the GP and care home liaison team were involved in this person's care. There was no recorded information about what foods to try and offer the person to increase their appetite or the supplement that were prescribed. The chef's dietary form detailed that finger foods were to be offered but this had not been incorporated in the nutritional plan. On one day it stated that food had been left in the person's room but there was no information recorded if this had been eaten or not. The lack of appropriate recording meant this person was not been sufficiently monitored in order to identify further concerns.

Targets for people's fluid intake had been written on the fluid charts. The charts we looked at had been totalled at the end of each day. However, when people had not met their daily target, there was nothing documented to indicate if staff had identified this, or if any action had been taken. For example, one person had a daily target of 1200mls. On one day in March the fluid chart showed the person had 675mls. There was nothing documented on the fluid chart or in the daily notes to indicate that staff had identified the shortfall or that action had been taken. In other plans we looked at there was no documented fluid intake target. Instead staff had documented guidance such as "encourage to drink plenty" but the definition of "plenty" was not defined.

Another person on a fluid chart also had a target intake of 1,200mls a day. We saw that on five recent days

this had been consistently under ranging from as little as 570mls to 950mls. On one of these days the total had not been added up by staff but we identified this person had no fluid recorded from 7pm until 9am the next day. This meant we did not know if staff were actively offering this person drinks or they had forgotten to record this. We saw a care leader meeting had been held in August 2017, in which the staff were told about completing these fluid and food charts. It was recorded in the minutes that lots of gaps had been identified and that care leads had a responsibility to do this. However this was still not being done and no further action from management had been taken in response.

Care plans were person centred in part, but this was not seen consistently throughout all of the plans we looked at. For example people's preferences for the food and drinks they liked had not always been documented. In one person's plan staff had documented the person was "unable to eat eggs" and "gets funny about eggs", but the plan did not detail what food the person did like to eat. This person was having their food intake monitored and the food chart for one day in March showed the person had been given scrambled eggs, despite it being documented that they did not like them. This meant people's preferences were not always adhered to.

Emotional well-being plans were not always detailed enough to provide staff with guidance on how best to support people. In one plan it had been documented the person could at times be low in "mood" and could be rude to staff. The guidance for staff was limited to telling the person that it was upsetting when they were rude. In another person's plan it had been documented that they became anxious easily; but the guidance for staff was "to be reassured and supported when feeling anxious" and "cup of tea and biscuits could be given." There was not enough clear guidance for staff on how to meet people's emotional needs.

Some of the plans detailed people's social needs and included details such as the type of television programmes they preferred or books and pictures they liked to look at. Other plans did not have this detail. Some of the wording used by staff in plans and daily notes did not always demonstrate a person centred approach to care and support. We saw statements such as "has had pressure care and repositioned every two hours" and "has been constantly shouting out, really loud" and "can be very vocal."

Plans had been reviewed regularly; however, when people's needs changed, the plans had not always been rewritten. Instead staff had crossed out recorded information that was no longer applicable. This meant it was sometimes difficult to clearly understand people's current needs. The majority of residents and relatives told us that whilst they were very happy with the care they or their relatives received, they were not actively involved with their care planning. One relative told us "I have not seen a care plan." However we did see evidence of where relatives had been invited to attend reviews and records showed some relatives had been involved in these.

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

The front of people's care plans had information about the person. This included a summary of the person's needs and what was important to them. There was also "All About Me" document in place in some of the plans which provided more detail for staff on people's lives before moving to the service. Plans in relation to people's personal hygiene needs were detailed and included people's preferences. Examples included 'likes outfits to be matching, likes to wear perfume' and 'likes wearing fluffy socks.'

Communication plans were detailed. When people had sensory deficits this was documented and the guidance for staff was clear, such as maintaining eye contact and speaking clearly. The management team were aware of The Accessible Information Standard (AIS) and informed us that this information was being

rolled out to managers and then relayed to all staff (AIS was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for the NHS and adult social care services to comply with AIS).

Activities were delivered in the home by a full time activity coordinator who was supported by a part time assistant and a network of volunteers. Activities available included music and movement, board games, movies, craft mornings, skittles, cake decorating and social events. In addition outside areas could be used for garden games and gardening activities. We saw that professional entertainers or musicians featured regularly in the programme also.

There was at times a lack of understanding demonstrated by staff about how to provide activities for people with dementia. We spoke with staff about involving people in the daily activities around the home aside from more structured activities. One staff told us "Staff could do more activities with people's different needs, but people with dementia just walk away." Another staff said "Some do activities and some don't want to do, they have dementia and don't seem to grasp it, the activities have got better." The acting manager told us "We are looking at daily activities and how to include people in these, we have more to do. People do some now and again. One person has got an old fashioned Hoover and will Hoover around the corridor and their bedroom."

People we spoke with were positive about the opportunities afforded by the home commenting "There is enough for everyone to do, we don't all like the same things", "I like the exercises to music. Sing and join in with the craft things", "I do enjoy doing the things here. Can do as much as you like or as little" and "I join in with the activities. I love reading. We have a library here." Staff told us taking part in the activities had impacted positively on some people's wellbeing and quality of life commenting, "When [X] first arrived she never came out of her room. Then she sat at a table watching things and now takes part in everything." For people that did not like to participate in group activity, one to one opportunities were provided by the activity staff.

The Cedars also contributed to the wider community. People external to the home were offered the chance to become volunteers, working under the supervision of the activity coordinator after an interview and training was provided. Pupils from local schools had the opportunity to complete work experience or the social aspects of their Duke of Edinburgh Award. A health and social care professional told us "There is a good activity scheme in place and I have observed residents engaging in them. It has been pleasing to learn that residents who choose to stay in their rooms are also visited by the activity coordinator and are engaged in conversation or such an activity as they choose."

People's concerns and complaints continued to be investigated and responded to in a timely manner. We saw in the complaints log, seven complaints had been raised in 2017 and one in 2018 up to the date of our inspection. People told us they felt confident to raise any concerns with the staff commenting "Not had any problems but I would tell staff about anything if I needed to", "Staff listen to what I say so know they would sort things out" and "Never had any problems but sure if I had they would be sorted." The complaints procedure was clearly displayed in the home and outlined how to make formal complaints and if necessary how to escalate them within the organisation. We saw that compliments had also been recorded about the support received from staff.

The home would seek advice and support from a local hospice in the event of a person nearing the end of their life. We saw that some people had advance wishes recorded for this time; however this was not the case for everyone. We saw one person's was not completed, and another person's plan stated a court appointee needed to be involved to support the person around these decisions. This had been documented

in May 2017 and nothing further was recorded to suggest this had been done. The acting manager told us that the training around end of life was not mandatory and currently 50 percent of staff were trained but further training had been scheduled. A local hospice was also booked to visit the home and give staff further guidance around supporting people at this time.

## Is the service well-led?

### Our findings

The registered manager was absent from the service on a period of planned leave. The head of care had stepped up into the role of acting manager since February 2018 and was going through the process to become a jointly registered manager for this period of time.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. However despite identifying some of the concerns we found during this inspection, action had not always been taken to address these. For example, One audit in December 2017 had looked at staff supervisions to ensure these were being completed. The audit stated that this had been met, however we saw this had not been done in line with the provider timeframes.

Although medicine audits had been undertaken, the majority of the issues we noted had not been identified. There had been some improvements in relations to missing signatures on administration records as identified during our previous inspection and by manager's audits. Missing topical medicine record signatures had also been noted during manager audits. The acting manager said this issue was being discussed at a staff meeting on the day of our inspection. However, the latest pharmacist advice visit dated November 2017 also noted missing signatures on medicine records, and yet this issue had not been addressed.

There was a lack of robust monitoring for documentation which placed people at potential risk. These records included behaviour that staff found difficult to manage, food and fluid intake and repositioning charts. These records were not completed appropriately and there was no evidence that the issues had been identified and raised with management. The acting manager told us "We have been looking at internal audits and where we can improve, we developed a home action plan looking at staff files, care plans and training. We recently had a meeting with a clinical pharmacist to review medicines and they gave feedback." The area operations manager commented "It's the precision around this, I think we have the processes and systems and training capabilities. But it's going beyond this to ensure it's habitual and embedded with staff, it's about the detail."

The home was currently reviewing the mealtime experiences people received using a new audit tool. We saw that for two weeks in February 2018 it stated that nutritional documentation was being completed accurately; however this was not what we found during this inspection.

We took enforcement action against the provider and imposed a positive condition on their registration at our last inspection in March 2017. This was because they had not made significant improvements since the previous inspection in January 2016 where we identified areas of concern. The registered manager submitted monthly improvement reports to demonstrate to CQC that specified areas of concerns were being monitored, audited and maintained to provide safe and effective care. In the report received before this inspection took place the provider stated that significant progress was made in all areas where concerns were identified and detailed how this had been achieved. At this inspection we found this to be incorrect and the provider remained in breach of Regulations and new areas of concern were identified.

The governance of this service has not been improved or maintained in order to effectively address the areas of concern which ensure people were receiving a safe and caring service. This is the second consecutive time the service has been in breach of this Regulation.

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

The new acting manager was supported by a head of care and the area operations manager who were all present for this inspection. Further support was being provided by the assistant operations director and the internal quality team who had visited the home every three months since the last inspection. The acting manager told us "I have a lot of support from the trust. An announcement has gone out about my promotion and people have been supportive. I sent all relatives a letter and I have informed residents. I have scheduled a residents meeting this Friday."

Staff spoke positively about the management changes in the home commenting "It's been a massive improvement, been a lot better with the registered and acting manager", "The management feel approachable", "We are a strong team. We have that support now, management are easy to talk to" and "We have come a long way, it might be slow but it's moving forward." One health and social care professional told us "The acting manager is very knowledgeable and proactive. There is an acting manager in situ currently. I have found them to be extremely approachable and accommodating."

Staff attended regular meetings within the home and there was a notice displayed of when these were scheduled. Staff told us they felt supported by the new acting manager and one staff commented "[X] is very approachable, it's a good team. Everyone is approachable, if have a problem they are helpful." The acting manager told us staff were encouraged to develop and progress if they wanted and that this was supported commenting "I always have the door open for staff." Staff were involved and made aware of important information in the home through a display board in the care office. This showed analysis information relating to people's weights, falls and reviews of care. This was shared with staff so that everyone had collective responsibility to take action around this.

People's experience of care was assessed through feedback opportunities. A comment and suggestion box was available for people to use in the front entrance and feedback was obtained after meals and implemented into menus. We saw where comments had been made by people these were considered and actions discussed.

The acting manager despite only being in post a short while was keen to develop the service. They were in the process of developing the quality monitoring for falls to gain further insight. The proposed tool looked specifically at correlating periods of the day when falls occurred and the location. This could then be shared with the team to query together possible reasons as to why this was and consider prevention methods around this. The acting manager had also been involved in a pilot for a care leadership programme which looked at areas including emotional wellbeing and conflict management. As things were raised during this inspection the acting manager included them in the agenda for the staff meetings planned that day. They said the purpose of this was to raise awareness and to implement appropriate action without delay. The acting manager told us "There are good staff who are caring and want to do their best for the residents."

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 10 HSCA RA Regulations 2014 Dignity and respect  We observed interactions where staff did not always act respectfully in regard to the people they supported or maintained their dignity. Regulation 10 (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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Risk assessments did not always contain enough detail on how to minimise the risk. Examples of unsafe practice were observed.</p> <p>Medicines were not safely managed. People with prescribed time specific medicines did not always receive them on time. Stock levels of some medicines were not regularly checked.</p> <p>Regulation 12 (2) (a) (b) (g).</p>

### The enforcement action we took:

Positive condition remains on provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The service continued to have ineffective recording in care plans and monitoring records. The lack of appropriate recording meant that risks to people may not be identified in a timely manner.</p> <p>Quality assurance systems were in place, however action had not always been taken to address concerns. There was a lack of robust monitoring for documentation. The governance of this service has not improved or effectively maintained in order to address the areas of concern and to ensure people were receiving a safe and caring service.</p> <p>Regulation 17 (2) (a) (b) (c) (f).</p>

### The enforcement action we took:

Positive condition remains on provider's registration.

Regulated activity	Regulation
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Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The deployment of staff was not always managed efficiently. There was not always sufficient staff to respond to people's needs in a timely way.  
Regulation 18 (1).

**The enforcement action we took:**

Positive condition remains on provider's registration.