

The Cedars Healthcare (CG) Ltd

The Cedar Grange

Inspection report

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Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Inadequate 

Is the service caring?

Requires Improvement 

Is the service responsive?

Inadequate 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service

The Cedars Grange is a care home providing personal care for up to 58 people. Some of the people in the home are living with dementia. People have access to their own bedroom along with communal spaces including lounges and gardens. The home is one adapted building that operates two separate wings. At the time of our inspection 53 people were living in the home.

People's experience of using this service and what we found

Risks to people were not managed in a safe way and when needed action was not taken to ensure people's safety. When incident such as falls had occurred, action had not been taken to reduce the risk of reoccurrence. Potential safeguarding incidents had not been investigated or report and there was a lack of confidence these had been dealt with appropriately, placing people at risk of harm. People did not receive their medicines as prescribed; some people did not receive their medicines at all. There was a lack of detailed guidance in place for 'as required' medicines meaning people may not have these when needed. There were no evidence lessons were being learnt when things went wrong.

People did not always have access to health professionals and when advice had been sought this had not always been followed. There were not enough suitably trained staff to support people.

There was a closed culture created in the home, where people relatives and staff did not feel concerns were listened to or action taken when needed. Complaints were not always recorded or actioned. The systems in place were not robust to ensure areas of improvement were identified. When concerns had been identified action had not always been taken. We had not been notified about all significant events within the home to ensure appropriate action had been taken.

People were not supported by staff to have the maximum possible choice, control and independence, as there was a lack of understanding about how people should be supported. All restriction had also not been fully considered. There was a lack of understanding around this and staff provided us with inconsistent views of how people would be supported.

Peoples cultural needs had not been considered and people were not able to communicate in a language or format that was import to them. People were not involved with their care or were not always able to make choices throughout their day.

People enjoyed the food and were offered a choice. The environment was adapted to consider people's needs. There were initial assessments for people which considered their needs and relatives were involved with this.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection

The last rating for the service under the previous provider was requires improvement, published on 22 December 2020.

This service was registered under the new provider with us on 5 July 2021 and this is the first inspection.

You can see what action we have asked the provider to take at the end of this full report.

Why we inspected

The inspection was prompted in part due to concerns received about safeguarding concerns and an ongoing police investigation in the home. A decision was made for us to inspect and examine those risks.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate ●

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate ●

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement ●

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate ●

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate ●

The service was not well-led.

Details are in our well-led findings below.

The Cedar Grange

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

The inspection was carried out by two inspectors.

Service and service type

The Cedar Grange is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection

Registered Manager

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection

The inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and professionals who work with the service. We also spoke with the police.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all this information to plan our inspection.

During the inspection

During our inspection we spoke with five people and seven relatives. We also spoke with the registered manager and the provider. We spoke with 12 staff including, care staff, kitchen staff, senior staff and deputies. We looked at the care records for 30 people. We checked the care they received matched the information in their records. We looked at records relating to the management of the service, including audits carried out within the home.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection of this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

- We identified three people who had not received their medicines for the two days prior to our inspection. This had not been identified and no action had been taken to resolve this. We alerted the provider who took immediate action to ensure these people received their medicines.
- Six other people had not received their medicines for one or two days prior to our inspection. These people were receiving their medicines on the day of our inspection. This had not been identified and no action had been taken to ensure they received these sooner. This meant people had been placed at risk of harm.
- People did not always receive their medicines as prescribed. One person was prescribed 'as required' medicine for agitation up to three times a day. For a month prior to our inspection they had received this medicine every morning and evening. There were no records to demonstrate why the person had received these. When we spoke to staff, they confirmed the person was not agitated every day, records we reviewed supported this. This meant this person had received medicines they did not always need.
- For other people 'as required' protocols for medicines were in place. Improvements were needed to ensure detailed guidance was in place for when these should be administered. For example, one person was prescribed medicines for a health condition, there was no guidance to state when they may need this. Staff we spoke with gave inconsistent information about when they would administer this. This meant people were at risk of not receiving their medicines when needed.
- Some of the 'as required' protocols did not match how the medicines should be administered. For example, one person's protocol stated, to be given up to two times a day, the Medicines Administration record (MAR) stated up to three times a day. This placed people at risk of not receiving their medicines in line with how they were prescribed. Other people did not have 'as required' protocol in place when needed.
- One person had refused their medicines for one month prior to our inspection. No action had been taken to escalate or resolve this. This placed this person at risk of poor health.

Assessing risk, safety monitoring and management

- People were placed at an increased risk of choking. One person had been assessed by Speech and Language Therapist (SALT) for a soft bite sized diet. The person's care plan stated they had a normal diet, not all staff we spoke with were aware of the SALT recommendations. We saw documented throughout the persons notes they consistently ate foods that were not soft, and bite sized, for example roast beef. The provider took immediate action to resolve this.
- Another person had been assessed by SALT and was choosing not to follow the recommended diet. There were no plans or risk assessments in place for this. Staff told us they had raised concerns with the registered manager about this and no action had been taken.
- When incidents and accidents occurred within the home, such as falls, there was not always evidence

reviews were taking place after these had occurred. Where care plans and risks assessments were in place for people, these had not always been updated to reflect these incidents. Action had not always been taken to reduce the risk of these reoccurring. This meant people were exposed to continued risk of harm.

- When people had displayed periods of emotional distress, not all these incidents were documented. There was no guidance, care plans or risk assessments to show how to support people during these times. Staff we spoke with gave us inconsistent accounts of how they would manage this. Staff told us they had raised concerns with the registered manager about this and no action had been taken. This placed people and others at risk of not receiving the support they needed during these times.

Learning lessons when things go wrong

- Although there was some documentation saying how lessons were learnt when things went wrong, there was no evidence this was put into practice. For example, falls continued to occur and concerns were not identified which meant these continued to occur. There were no reviews taking place after incidents occurred which meant people continued to be exposed to the risk of harm.

Preventing and controlling infection

- We were not assured the provider was using Personal Protective Equipment (PPE) effectively and safely. On arrival not all staff were wearing a mask as required. We observed on numerous occasions staff adjust and put on their masks when we entered the room. This meant people and staff were exposed to the risk of cross infection.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

- There were safeguarding concerns within the home that are currently part of a police investigation.
- Although there were procedures in place to manage safeguarding concerns, when incidents of potential abuse had occurred, they had not always been appropriately documented, investigated or reported to the safeguarding team so they could consider any further actions. This included unexplained injuries and incidents between people. This placed people at risk of harm.
- During our inspection we were alerted to an allegation of a potential theft. We were told the registered manager was aware of this. No action had been taken to investigate this and it had not been reported to the safeguarding team or police. We raised this with the provider who took immediate action to resolve this.
- Staff raised concerns with us about the action taken when they had reported incidents. They told us of incidents they had reported, and no further action had been taken. Staff told us they did not feel confident when they raised incidents with the registered manager, that they would take appropriate action to keep people safe.

People were not always protected from potential abuse. This placed people at risk of harm. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff and recruitment

- We received mixed reviews on staffing levels in the home. One person told us, "I think there is room for a little increase in staffing". Another person said, "I have never had to wait for anything".
- Staff we spoke with felt there were not always enough staff. One staff member told us, "Not really enough in mornings or weekends, we are rushing about, and it means residents wait for support." Another staff member said, "Always short staffed, residents sometimes wait to get pressure relief as call bells constantly

going. Afternoons and weekends quite bad, Service Users would have to wait to go to toilet, sometimes they'd have an accident." Staff we spoke with told us they had raised concerns with the registered manager about this and their concerns were dismissed. This meant people were at risk of not having their needs met.

- The provider used a dependency tool to calculate the number of staff required based on people's individual needs. Although there was the correct amount of staff available based on this tool, we could not be assured by the accuracy of this. For example, as people did not always have care plans in place that reflected their needs, we could not be assured the information inputted into this tool was correct.
- Other people did not always have the support their care plans told us they needed. For example, one person had several unwitnessed falls. The care plan stated they should be supervised when mobilising. This meant this person had not been supervised when mobilising as they had unwitnessed falls. Staff we spoke with told us there were not always staff available to ensure this person was supervised during these times.
- During our inspection we observed people did not have to wait for support and when they requested support is was provided to them. However, health professionals described the home as chaotic and understaffed.

There was not enough staff to meet people's needs and keep them safe. This placed people at risk of harm. This was a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We saw staff had received the relevant pre employment checks before they could start working in the home.

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

- There were no restrictions placed on visiting and visitors could access the home freely.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection of this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- All people had a capacity and best interests decisions in place, regardless of whether or not they had been assessed as lacking capacity. This is not in line with the principles of the MCA.
- When applications had been made for DoLS, the provider had not always considered all restrictions that had been placed upon people. For example, when people were using bed rails, sensor mats, the locked doors within the home and restrictions on using the stairs. There were no care plans or risk assessments in place identifying how people were supported in the least restrictive way whilst these applications were considered.
- Other people had DoLS authorisations in place. There was a matrix available showing who these people were. Staff we spoke with gave inconsistent accounts of how they would support people. This placed people at an increased risk of being unlawfully restricted.
- Although staff told us they had received online training, there was a lack of understanding around capacity and consent.
- We could not be assured all capacity assessments were accurate, as information given to people in order to assess their capacity had not been presented in a format or language they could understand.

The principles of MCA were not understood or followed within the home. This placed people at risk of harm. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live healthier lives, access healthcare services and support

- People did not always have access to health professionals. For example, one person had sore skin, their notes documented staff should liaise with the district nurse team, there was no evidence this had been done.
- Another person needed a referral to be made to ensure they had equipment to support with their sore skin, there was no evidence this referral had been made and the sore skin continued. Staff could not confirm these actions had been taken and there were no plans in place to manage these concerns. This placed people at risk of harm as their health needs were not managed.
- Another person had a medical concern and paramedics requested this was followed up with the GP, there was no evidence this had been completed.
- When advice had been sought from professionals this had not always been followed. One person had been seen by a health professional and it was recommended to push fluids for a health condition. There was no care plan in place for this and some of the staff we spoke with were not aware of this. A fluid chart had recently been introduced which identified the person was not drinking enough fluids. No further action had been taken in response.

People health needs were not consistently managed, and professional advice was not always sought or followed. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- Staff did not always have the skills or knowledge to support people. Relatives raised concerns with us around the skills of the staff that supported their relations.
- Although staff had received online training, we could not be assured they received adequate training to meet people's needs. There had been an incident within the home that had required emergency first aid. Since this incident had occurred not all staff had received face to face training in this area. Some of the staff told us they did not know how to complete emergency first aid or felt confident to do so. This placed people at risk of not receiving emergency first aid if needed. The provider took action to resolve this after our inspection.
- Staff had not received training to support people to eat and drink in a safe way and we found concerns with the diets people received. This placed people at risk of harm.
- Staff told us they had not always received training in key areas, including dementia. One staff member said, "There is nothing in care plans to know how to support people, I have raised my concerns and asked for training, but nothing is done. It's getting worse and we don't know how to help people."
- Staff also raised concerns with the quality of the training. One staff member said, "Hardly any training, couple of manual handling sessions face to face, everything else done online and felt made to rush."
- Improvements were needed to ensure staffs understanding of training provided, as staff told us they had received MCA training however they did not always know how to support people with this.

Staff had not always received adequate training to ensure they were able to support people in a safe way. This placed people at risk of harm. This was a breach of regulation 18 (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- There was an induction process in place for new starters. This included online training and the opportunity to shadow more experienced staff whilst getting to know the people they were supporting.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were assessed before they started using the service. This considered people's gender, culture and religion. People's physical and health needs were also assessed and considered. This information was not always reflected in the care people received.
- People and those important to them were involved with the initial process.

Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live healthier lives, access healthcare services and support

- People's oral health care was assessed to ensure people received the support they needed.

Supporting people to eat and drink enough to maintain a balanced diet

- People enjoyed the food available and the mealtime atmosphere was relaxed. One person said, "The food is OK I get a good choice and its well-presented".
- There was a choice of meals available for people. We saw people were verbally asked what they would like and when they chose different options this was made available for them.
- People had hot and cold drinks available on tables beside them.
- When needed people received support to eat and drink and staff took time with people and this was not rushed.

Adapting service, design, decoration to meet people's needs

- The home and the environment were clean. The home had been designed to meet people's needs, corridors were wide, and the lounges were large to ensure people had space to move around.
- Adapted equipment was available to support people, including hoists and bathrooms.
- There was garden and activity area that people could access.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection of this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- Although people's cultural needs had been assessed when they moved into the home, these had not been considered since. There were no care plans in place to consider how people could be supported with their culture and staff confirmed they did not consider this for people.

Supporting people to express their views and be involved in making decisions about their care

- Although people were involved in making some day to day decisions, they were not consistently involved. People told us they were not always offered choices. For example, what time they went to bed and what time they got up in a morning. On the day of our inspection we observed that many people in the home were up early on arrival. Staff told us this was some people's choice however for other people it was to manage risks. One staff member said, "The night staff get people up as we wouldn't be able to (day staff). Some people have to get up so we can keep an eye on them in the lounge."
- There was no evidence people were involved with their reviews. Relatives told us they were not involved with reviews and did not always feel they were kept up to date. This meant people and those important to them were not involved with decisions made about their care.

People were not actively involved in their decision making or offered choices. Their cultural needs were not considered. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Respecting and promoting people's privacy, dignity and independence

- Relatives raised concerns about people's dignity and appearance. One relative said, "None of the residents look very clean. They look dirty, not very well kept". Another relative said, "There is an on-going problem with the clothes all decent clothing has gone missing wearing same clothes week after week and they were filthy and this was for months, clothes not changed, issues with not doing personal hygiene". They told us they had raised their concerns with the registered manager however no action had been taken.
- Relatives also raised concerns with us about the number of baths people received. Some of the people we spoke with told us they did have baths and some people said they would like more. The records we reviewed showed us people had showers or baths and we saw people had received baths on the day of our inspection.

Ensuring people are well treated and supported; respecting equality and diversity

- Both relatives and staff were happy with the staff team that supported them and felt they were kind and

caring. One person said, "All the girls and boys are very good, they have a very hard job to do, but they do their best." Another person said, "They are all kind to me a little rushed but lovely." Relatives we spoke with raised no concerns about the staff team.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection of this newly registered service. This key question has been rated inadequate. This meant services were not planned or delivered in ways that met people's needs.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Information was not always available for people in a format they could understand. One person did not speak English as their first language and no staff were able to speak in their first language. This meant the person was unable to communicate their needs to staff. The person's personal evacuation plan also guided staff to use sign language in an emergency, however staff were not aware of this and told us they did not know how to sign. There was no evidence to suggest the person understood sign language. This placed this person at an increased risk of not receiving the support they needed and may impact on their wellbeing.
- Where people were living with dementia, their communication needs had not always been fully considered. Staff told us they could use picture cards to help people make choices, however these were in the office on the day of our inspection and not used.
- Other people had communication plans in place, however, where support had been identified there was no evidence this was always implemented. For example, when people would communicate through third parties.

End of life care and support; Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- When people were in receipt of end of life care, there were no plans in place to identify how staff should support people during this time. Staff gave inconsistent information as to how they would support people. This meant people were at risk of not receiving the support they needed during this time.
- People did not always have care plans or guidance in place to ensure their needs were met. Staff consistently gave inconsistent views as to how they would support people.
- People did not always have control over their lives as people were not always encouraged to express opinions. For example, there was no evidence of how all the people living in the home contributed to meetings, for example, if they chose not to verbally communicate.
- There was no evidence people and their relatives were involved in reviews of their care. One relative told us, "I was initially involved but there hasn't been anything since. No one has told me anything has changed or been reviewed, I don't know."

People were not actively involved in their care or decision making. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- There was a complaints policy in place. People and relatives told us they had raised concerns and were not happy with how these had been actioned. They told us the registered manager was often not available and uninterested.
- When formal complaints had been made and the provider had been made aware of these, action had been taken to resolve these and procedures followed. Not all complaints had been recorded or escalated to the provider to ensure action was taken.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were not always supported to access a variety of activities in line with their preferences. We observed limited activities taking place; however, most people were not actively involved, and televisions and radios were on in communal areas that people seemed uninterested in.
- We received mixed views on the activities within the home. One person told us, "There is always something to do if I want. Another person said, "It can be a bit boring, not a lot going on."
- People told us their friends and families could visit when they wanted to. One person told us how their family took them out and the home supported this.

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection of this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Systems and procedures in place were ineffective to ensure incidents and accidents were investigated or reported when needed.
- When unexplained injuries had occurred, it was recorded these had been investigated. There was no evidence of these investigations. There were no audits in place to identify these investigations had not been completed. There was also no oversight from the provider to ensure these actions had been taken.
- When falls occurred, records showed sensor alarms had been considered or put in place to keep people safe and reduce the risk of reoccurrence. On review we saw these sensors were not in place or being used, as stated on incident forms. This meant the provider had not taken the action they said they had to keep people safe and reduce the risk of reoccurrence.
- When audits took place and areas of improvement identified, no action had been taken. For example, three months prior to our inspection, the infection control audit had identified an unclean area.. No action had been taken to resolve this and the area remained unclean.
- There were no care plan audits in place, so there was no way of monitoring if care records were accurate and up to date. We found these records were not up to date and this exposed people to ongoing risk of harm.
- Audits had failed to identify when health professionals' referrals or advice had not been followed.
- Medicines audits had failed to identify that people were not receiving their medicines as prescribed and that people did not have detailed 'as required' plans in place.
- Audits had failed to identify there was no guidance in place for staff to follow when people were at the end of their lives.

Systems in place were not robust to ensure people were protected from harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Although the provider had notified us of some significant events, such as deaths, they had not notified us of all events that occurred within the home. For example, when there were allegations of abuse, safeguarding concerns or all serious injuries. This meant we were unable to check if people had come to harm.

This is a breach of regulation 18 of The Care Quality Commission (Registration) Regulation 2009.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- We could not be assured duty of candour requirements were understood and met, as incidents were not always investigated or reported externally when needed.
- Relatives we spoke with were not always aware when incidents had happened within the home. For example, one relative told us their relation was not at risk of falls, however we saw recent falls had occurred.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There was a lack of confidence from staff, people and relatives around the registered manager and the action they would take to ensure people's safety. One staff member said, "I've never felt supported by manager, whatever I raised it was brushed under the carpet." Another staff member told us, "The last supervision was the beginning of year, you put opinions or issues across but don't get listened to. Things raised with management but not followed through". A relative commented, "The manager is always on phone and never available to talk to you."
- The home did not create a positive culture for people. We found there were themes of poor communication and documentation, this placed people at risk of not receiving good outcomes and the support they needed.
- We found when concerns were raised or incidents were reported, there was a tendency to deal with these inhouse and not share the information with other professionals, as needed. This created a closed culture within the home.

Working in partnership with others

- The service worked with other agencies to inform people's care and support. However, we saw professional advice was not always followed or acted on. This placed people at risk of harm.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Some people had been asked for feedback on the home, through surveys. Where areas of improvement had been identified action was in the process of being taken. There was a you said, we did notice board in the home so people could see the progress being made.

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 18 Registration Regulations 2009 Notifications of other incidents We had not been notified of all significant events that had occurred within the home.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The principles of MCA were not followed.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not always received adequate training to ensure they were able to support people in a safe way. There was not enough staff to meet people's needs and keep them safe.