Healthcare Homes (LSC) Limited

Cedar Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 8th and 14th January 2019. The first day of the inspection was unannounced. We carried out this responsive inspection because of concerns raised by health care professionals and the local safeguarding authority.

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

Cedar Court is a purpose-built nursing home, able to provide care and support for up to 63 people whose care needs are associated with physical needs, mental frailty and/or dementia. At the time of our visit 47 people were using the service.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. In the absence of a registered manager the service was operated by operational relief support manager.

We found the staffing levels to be inadequate to support the high number of people who required two staff to support them. As a result, staff spent most of their time carrying out care-related tasks in people's bedrooms, which meant they were not able to spend sufficient time engaging with people. With staff being busy caring out their tasks, some people were deprived of the care and support they needed for periods of time. This was evident from our observations and discussions with staff and people's relatives.

Infection control monitoring within the service was in need of improvement. We found that bathrooms and some communal areas were not always clean.

The 'grab bag' that was supposed to be used in case of evacuation from the building contained a list of the residents that was up to date. However, the 'grab bag' first aid kit contained bandages that had expired in 2016.

Risks to people's health, safety and well-being had been assessed and were included in people's care plans. Records included guidance for staff to follow to protect people from the risk of harm. However, risks were not always managed appropriately in practice.

Some people told us they liked the food, but others found it was not to their taste. The menus displayed in the dining rooms was not always up to date. The dining experience was not positive for people who lived in the home.

Health care professionals told us that the service had not always sought medical advice in a timely manner.

Whilst some staff treated people in a kind and compassionate manner, this was not always demonstrated by all staff. People could not be assured their confidentiality of information was protected.

People were not always provided with opportunities to engage in meaningful activities, which depended on the availability of staff.

The provider had a complaints procedures, however, there was no evidence of all complaints being investigated and provided with a response.

Quality assurance systems were not always effective and did not identify the shortfalls we found during this inspection

People were supported to receive their prescribed medicines safely.

Appropriate arrangements were in place for reporting and reviewing accidents and incidents. This included auditing all incidents to identify any trends or lessons to be learned.

Safety checks for gas, emergency lighting and hoists had been completed and PAT testing was up-to-date.

Staff employed by the service had been subject to pre-employment checks to make sure they were suitable to work at the service and people felt cared for safely.

Staff completed induction when they started work, which included mandatory training and shadowing experienced colleagues. Staff told us they received one-to-one supervision and this was demonstrated by the records we checked.

Staff ensured people's rights and best interest by working within the principles of the Mental Capacity Act (MCA) 2005. People were supported to make choices and decisions about their care.

People's care was reviewed and care plans updated to ensure they reflected people's current needs.

Staff felt supported by the operational relief support manager and they were able to approach them for advice and guidance when they needed. People and their relatives spoke highly of the operational relief support manager and the way they ran the home.

We recorded four breaches of our regulations. You can see what action we have told the registered persons to take at the end of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staffing levels were insufficient and therefore staff could not be effectively deployed and available at all times to meet people's needs.

People were not always supported to have access to health care professionals in a timely manner.

Staff knew how to protect people from abuse or poor practice.

Is the service effective?

Requires Improvement

The service was not always effective.

We received mixed feedback on the quality of food served to people.

Staff understood the requirements of the Mental Capacity Act 2005 (MCA) and how this applied to their daily work.

Staff had completed training to enable them to provide people with care effectively.

Is the service caring?

Requires Improvement

The service was not always caring.

Whilst some staff members treated people in a kind and compassionate manner, this attitude was not always demonstrated by others.

The dining experience was not positive for people who lived in the home.

People were not assured their confidentiality of information was protected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There were few opportunities for bed bound people to participate in activities, and they told us little was offered to occupy their time.

People's care was reviewed and care plans updated to ensure they reflected people's current needs.

People and their relatives knew how to raise any complaints or concerns. However, there was no clear record of what had been done to address some of the concerns raised.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Although regular audits were carried out to assess the quality of the service, these were not used effectively to identify the areas where improvements were needed.

Regular meetings were organised to keep staff up-to-date and reinforce the values of the organisation and their application in practice.

Staff and people spoke highly of the operational relief support manager and the way they ran the home.

Cedar Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 8 and 14 January 2019 and was unannounced. The inspection on 8 January was carried out by three inspectors and two experts-by-experience (ExE). An ExE is a person who has personal experience of using or caring for someone who uses this type of care service. Our ExE had thorough knowledge of supporting people who were living with dementia. On 14 January 2019, one inspector returned to the service.

Concerns about staffing levels and people's safety had been raised with us prior to the inspection. Having taken these concerns into consideration, we decided to bring our planned inspection forward. We reviewed information we held about the service. This included statutory notifications and information received from the service, the local authorities and other health care professionals. A notification is information about important events which the provider is required to send us by law. We also contacted commissioners (who fund the care for some people) of the service and asked them for their views.

Some people could not tell us what they thought about the service because they were unable to communicate verbally. Therefore, we used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care in order to understand the experience of people who could not talk to us. We observed how people were supported at lunch and watched how staff interacted with them at that time.

During the inspection we spoke with 12 people who were using the service. We also talked to seven relatives of people. We spoke with the operational support relief manager, the deputy manager, the regional director, the registered nurse, the Care Home Support nurse visiting the service and three members of staff. We looked at the care records for five people, including their assessments, care plans and risk assessments. We looked at how medicines were managed and examined the records relating to this. We looked at five staff recruitment files and other records relating to staff support and training. We also looked at records used to monitor the quality of the service, such as the provider's audits of different aspects of the service.

Requires Improvement

Is the service safe?

Our findings

People who were at risk of developing pressure sores had pressure relief equipment in place. Most pressure relieving equipment was being used correctly and no one who had been identified as at risk had developed a pressure sore. However, one air mattress setting did not match the person's weight. Although the correct weight was noted in the care plan, the weight specified in the air mattress monitoring form differed from the one recorded in the person's care plan. We had to ask twice during the inspection for the setting to be changed so it reflected the person's weight. This meant this person was not protected from developing pressure sores.

The environment in which people were provided with care was not always clean. We noted early in the morning on the first day of the inspection that the communal bathrooms in the dementia wing were dirty as the night staff were busy carrying out other care-related tasks and had no time to clean the bathroom. These areas were promptly cleaned at the beginning of the day shift.

The environment was not always safe for people. The sluice room in the residential wing, containing chemicals, was equipped with a key-pad to prevent unauthorised access to potentially harmful substances. However, the sluice room was left open in the early hours of the first day of the inspection.

The period of validity of some of the equipment to be used in the case of an emergency had expired. We checked first aid kits and found one of the emergency grab bags to be out of date. The emergency 'grab bag' holds things which are essential if people need to leave the home in a case of an emergency. Some of the bandages in the first aid kit had expired in 2016 and would not be able to be used in case of an emergency.

The service worked well with other health professionals to ensure people's health needs were met. The care records we reviewed showed people were supported to access healthcare services such as GPs, Care Home Support (CHS), district nurses, a speech and language therapist (SALT) and social workers. However, one professional visiting the service told us that sometimes people were not provided with the assistance of health care professionals in a timely manner. They told us, "On Monday we were told that [person] had been in bed since Friday. [Person] had a fractured hip. How many nurses had been walking there and had not seen anything? How can you be giving personal care to somebody with such a massive fracture and not see anything?".

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

At this inspection we found insufficient staff deployed to support the high number of people who needed the assistance of two staff members. This was evident from our observations and discussions with staff and relatives.

Prior to our inspection we had received concerns that there were not enough night staff to support people safely. We started our observation early morning on the first day of the inspection to check how people were

being supported by night staff. We found that the numbers of staff were insufficient to support people in the dementia wing.

We observed how one person, already up and dressed, went to another person's bedroom touching their belongings. This person was known to be in the habit of getting up early in the morning and attempting to go to other people's bedrooms or go to the other units. There were no staff available to assist or re-direct that person. Another person was crying for help standing half-naked with their walking frame in the open door of their bedroom. This person was unable to use the call bell and relied on calling for staff to assist them. However, there were only two staff members and one nurse working in the dementia wing and they could not hear the person as they were occupied in another part of the building. The service utilised a dependency scoring tool to establish how many staff were needed to safely support people with their needs. This person's dependency tool score in the mobility section was zero, however, their care plan stated that the person was at high risk of falls. According to the system used by the provider, the person should have scored at least three. This meant the tool was not being used effectively to predict safe staffing levels. We provided the operational support relief manager and the regional director with our feedback on the staffing levels at night. We reported our concerns to the operational support relief manager who told us they were going to review dependency tools for every person living in the service and keep these under review on a monthly basis.

People and their relatives told us that current staffing levels were insufficient to meet their needs. One person told us, "There are not enough staff, the boss says there's plenty of staff but I don't know where they are". Another person said, "The staff are always saying they need more staff, so it's not just us". One person's relative complained, 'I've been up here when there is nobody and I can't find anybody (staff). Happened just now, nobody around".

People told us that due to the low staffing levels their needs were not always met in a timely manner. One person told us they had used their call bell but no one had come, or staff had come to the door to inform the person they would come back again later. The person told us, "It can be half an hour, not good when you want the loo. I'm not the only one with bell problems, you hear them ringing all day sometimes". This was confirmed by other residents. Another person said, "I hear that quite often, 'we haven't got time'".

One person told us they were reluctant to go to the dining room for meals because the residents were taken there too early and brought back too late. The person said, "The staff say they have to clear the dining room before they can take me back. Except today". Other residents told us that due to insufficient staffing levels they were not properly assisted with their personal care. One person told us they were always assisted with bed wash while they preferred to have a bath. They told us, "I would like to have a bath more often, I would like to be changed more often and would like to be hoisted out of bed and into bed when it suits me, not the staff". During our inspection we noted that one person had their last personal care recorded in their care logs two weeks prior to our inspection.

On the first day of our inspection we observed that there were not enough staff to support people safely. There were times when pairs of staff were required for particular care tasks, leaving insufficient numbers of carers to monitor peoples' safety. This resulted in people being left unsupervised in the communal areas for longer periods of time. For example, in an unsupervised communal area a person with limited mobility was trying to get up from their chair, however, they were unable to do so as staff were busy assisting other people who required two members of staff for their care.

Staff provided us with mixed feedback on the staffing levels. A member of staff told us, "Sometimes when we have four (staff members) instead of three, it makes it easier". However, another member of staff said, "We

have enough staff on shift. I don't know why they would feel rushed".

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

People and their relatives told us they felt people were safe living in Cedar Court Care Home. One person told us, "I am happy here. I feel safe. I had falls at home so came here". One person's relative said, "She is safe. Nothing ever worries me about that".

Staff were aware of their responsibilities for protecting people against the risk of avoidable harm and abuse. They were able to give us hypothetical examples of a risk of someone being abused and the steps they would take to protect that person. Staff told us they were able to recognise signs of abuse. A member of staff said "If I suspected abuse, I would report this to the management team. If nothing were done, I would report this to the Care Quality Commission (CQC)".

Individual risk assessments had been undertaken to enable people to retain their independence and make their own choices, whilst minimising risk. Systems were in place to identify and reduce the risks to people using the service. Risks associated with people's health and welfare, including the risks of falls, nutrition, dehydration, incontinence, developing pressure wounds and using bed rails had been assessed. Staff were provided with relevant guidance to follow to minimise the risk of harm.

The provider had an ongoing staff recruitment programme with procedures which ensured people were supported by staff with appropriate experience and character. Staff had undergone relevant recruitment checks as part of their application and all the checks were documented. These included the provision of suitable references and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Recruitment files showed that a thorough system was in place for pre-employment checks.

Staff understood how to report accidents and incidents and knew the importance of following the procedures in place to help reduce risks to people. We saw the service had analysed each accident and incident which had involved people who lived at the home. As a result, appropriate steps could then be taken to help prevent incidents and accidents from happening again.

Prior to our inspection we received concerns that medicines were not managed safely. At our inspection we found that the manager had taken action to improve. Medicines were stored and administered safely and securely. All the people we spoke with told us they received their medicines regularly and they were observed whilst taking them. We found that medicines were given on time and the medicine administration records (MAR) were completed to show what medicines people had received, as well as when and in what amounts they received them.

Regular checks and tests were completed to promote safety in the home, such as weekly fire alarm tests, as well as the checks of firefighting equipment. The service took appropriate action to reduce potential risks relating to Legionella disease. Staff reported any maintenance requirements and these were resolved in a timely manner.

Each person had a personal emergency evacuation plan (PEEP). A PEEP sets out the specific physical and communication requirements that each person has to ensure that people can be safely moved away from danger in the event of an emergency.

Requires Improvement

Is the service effective?

Our findings

We received mixed but mostly positive opinions from people and their relatives regarding staff's skills and knowledge. One person's relative told us, "Staff are knowledgeable". One person pointed out, "Some staff are better than others". Another person said, "I wouldn't say the staff are well trained, they don't seem to know what to do". A member of staff told us, "I think the training provided to us is really good". The management team told us and records confirmed staff were provided with an on-going training. New starters were booked to attend training in records keeping, communication and management of medicines. We looked at the training records and the overall compliance was 85.7% in all training areas.

All new staff completed induction training which included training in areas such as safeguarding, moving and handling and health and safety. They also completed a probationary period. Newly employed staff shadowed more experienced staff for two weeks and had their competencies assessed. A member of staff told us, "I have done my induction. This is my first job in care and the induction prepared me well for my role".

Following their induction, staff participated in a rolling programme of training. We looked at the training records which showed staff had completed a range of training courses which included: safeguarding, first aid, moving and handling, fire safety and dementia awareness. Staff spoke positively about the training they received to help them support people safely and effectively.

Records showed staff had received regular supervision sessions and staff confirmed this while talking with us. Supervision sessions enabled staff to discuss their personal development objectives and goals. We saw that responsive supervision with 16 staff members took place when a fire drill had taken too long.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA. Some people were unable to give their consent in some areas of their care. Records showed that in such cases the person's relatives and health professionals were involved to ensure decisions were made in the person's best interest. Staff were knowledgeable about the principles of the MCA. A member of staff told us, "Everybody has got the right to make their own decisions. You can't assume people can't make their own decisions".

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The service had made applications to the local authority when people had needed to be deprived of their liberty for their own safety. We saw that any conditions were being met and staff were providing care in the least restrictive way.

We received mixed but mostly negative feedback about the quality of the food people received. Most people

told us they did not always enjoy the food served at Cedar Court Care Home, although some people gave more positive feedback. One person's relative told us, "She is eating well, portions are very good for her, not too big", and one person said, "If you want a second helping, you can ask". However, one person remarked, "Food used to be very good, but the chef left". Another person added, "Some days it's good, (today) I suppose it's adequate".

People were not always offered a choice of food and staff were not always knowledgeable about what was being served to people. On the first day of the inspection early in the morning we noticed that menus displayed in dining rooms were a few days out-of-date. This was quickly addressed by staff who brought current day menus to every dining room in the service. However, staff appeared to be unaware as to what they were serving up. One person told us, "Staff don't seem to know what the food is".

The system of asking people what options they would like to choose from the menu had been stopped. As a result, the chef was unaware of how many portions of each choice to cook. The kitchen was preparing food options on a 50/50 basis and they soon ran out the food of one choice on the day of inspection. As a result, one dining area was only offering one choice for the main course. It was also noted that carrot and coriander soup was served for both lunch and supper that day.

We saw that one person did not like any of the food served on the day. The person asked for an alternative which was brought to them undercooked. The person refused to eat it, commenting that food was "soggy and horrible".

People had their nutritional needs assessed by the service. People who were identified to be at risk of malnutrition or dehydration had appropriate monitoring charts in place. However, during our inspection we noted that people with limited mobility could not always reach their drinks and we did not see staff regularly offering drinks to people who lacked the capacity to drink themselves. In a number rooms of people with limited mobility the fluid level in the beakers remained unchanged for several hours. We informed the management team about our concerns.

The interior of the service premises was dementia-friendly. For example, carpets were free of any patterns that might cause confusion. All toilet doors were painted yellow so that people knew where the toilets were both in their rooms and in the communal areas. The design allowed people to walk through the corridors and return to the main communal rooms without being faced with 'dead ends', which could be frustrating for people with dementia.

Requires Improvement

Is the service caring?

Our findings

People using the service and their relatives spoke positively about staff and the care they received. One person's relative told us, "They are looking after her marvellously. You can't fault them. [Person] thinks she's on holiday". Another person's relative praised staff saying, "Carers all very nice, all very helpful. They talk to us, they all have mum's best interest at heart".

During our observation on the first day of the inspection we noted that staff did not always treat people with respect and dignity. During lunchtime we saw that staff were talking mostly about 'feeding' people instead of assisting people with their meals. Food was served in a very impersonal manner with no communication. One person told us, "They respect me as a person", however, the person added that "Some discuss me as a person within earshot which I find very hurtful".

One person told us, "The night staff leave a lot to be desired". This person had requested a female carer only, at nights and for personal care. The person had needed to be transferred to a hospital which required help with personal hygiene/toileting. They had been quite upset when they had been sent with a male carer escort. Another person confirmed this to be a regular occurrence due to the low staffing levels. The person told us, "I requested no men but they're so short staffed".

During the inspection we saw that the current staffing levels forced staff to hurry with their tasks which had an impact on their quality of work and interaction with people. On a number of occasions, we observed staff walking past without checking on a person or just calling in to say 'hello'. As staff were rushed to complete their tasks in the morning this resulted in people not being treated in a dignified way. For example, one person was assisted with their clothes, however, they were wearing their trousers back to front.

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

People's care plans described ways in which people should be supported to promote their independence. During the inspection, we observed care workers provide prompt assistance but also encourage and prompt people to build and retain their independence. For example, people were encouraged to choose what they wanted to do and where they wanted to go throughout the day.

People told us they were involved in care planning. One person said, "I made it quite clear that I wanted to be involved". People were able to receive visitors at any time and they could talk to their guests in the privacy of their own rooms.

Confidentiality was not always maintained. For example, on the first day of the inspection we saw that people's bedroom folders were taken out of their bedrooms and left open in a corridor. Anyone passing by could have access to people's confidential information.

The service had an equal opportunities policy in place. This confirmed the provider's commitment to equal

opportunities and diversity. The policy included cultural and religious backgrounds as well as people's gender and sexual orientation. A member of staff told us, "We treat everyone as an equal, as we would like to be treated".

Requires Improvement

Is the service responsive?

Our findings

Each person had their needs assessed before they moved into the home. The aim was to make sure the home was appropriate to meet the person's needs and expectations. Following the initial assessments, care plans were prepared to ensure staff had sufficient information about how people wanted their care needs to be met. However, a health care professional visiting the service told us that the initial assessment did not always reflect the actual needs of people which resulted in high a number of referrals.

People were not always supported to follow their interests and undertake activities. One person who had not been able to attend activities lately said the activities coordinators always called on them 'for a chat'. Another person told us, "I'm occupied as much as I want to be, I do the activities I want to do. We get a diary and there is plenty of choice". However, some people told us that due to poor organisation they did not always participate in the activities of their choice. One person told us, "You get a list of activities but they don't always happen, I never see them". On the day of the Inspection there were to be two activities offered, one upstairs in the morning and one downstairs in the afternoon. The afternoon activity was moved upstairs and people who were not aware of and the move missed the activity. Other people complained about lack of activities organised outside of the service. One person told us, "I would like to get out more into town". We looked at the records and found there were plans for the residents to go to Cotswold Wildlife Park at Easter. However, there were no planned or confirmed other outings between the time of our inspection and Easter.

People who stayed in their rooms told us they lacked any social interaction. We noted that one person had no activities recorded for a period of 19 days. Another person had only two activities recorded for December 2018.

Records showed there were regular formal review meetings with people using the service and relatives. At these meetings people's care was discussed and reviewed to ensure people's needs were being met effectively.
Staff we spoke with were very dedicated to their roles. We found that staff were very knowledgeable about people's past lives, care needs, likes and dislikes. Staff were able to provide us with this information prior to us meeting people.

At the time of our inspection no one at the service was receiving end of life care. However, staff told us people's advanced wishes would be respected. People's records included their decisions about their end of life care. The advanced care plans recorded people's wishes and choices as to how they would like to be treated in their last days.

The service supported people to have access to information. People had access to their care records and staff informed people about all aspects of their care. Where appropriate, staff explained documents to relatives and legal representatives of people. Where required, documents could be provided in large print or in a foreign language.

People and relatives told us they knew how to complain. One person said, "I would call the first person I saw

and say I wanted to see the manager".

Complaints were not always being handled effectively. One person told us, "They would act on it, they wouldn't fob you off with any old tale". However, one person's relative told us, "I like to do the washing myself and there are notices around to tell staff. But they are ignored and perhaps three days later the laundry comes back, unwashed so it has been dirty for three days when I take it to wash. I have raised this but it has been ignored". We looked at the complaints log and saw the issue raised by the relative had not been recorded and investigated. The service had a complaints policy and procedure, however, there was one complaint logged without any information about the nature of the complaint or its outcome.

Requires Improvement

Is the service well-led?

Our findings

Cedar Court Care Home has a history of not providing safe, effective and responsive care. At our inspection in October 2017 we found concerns relating to people's safety, staffing levels and the leadership of the service. We rated the service as inadequate. We inspected the service in June 2018 and found the service had made improvements. However, at this inspection we found that the improvements had not been sustained and the service was again not meeting the requirements of the regulations. The service did not have consistent leadership to drive and sustain improvements.
There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager had left the service in November 2018. In the absence of a registered manager the service was being run by an operational relief support manager, who had been at the service since December 2018.

People were encouraged to provide feedback on their experience of the service. The results of the latest survey for the service were lower than average results for all other homes of the provider. We saw there was an action plan in the form of 'You said -We did' which stated the service was to review the activities planner, the menus and to send letters to invite relatives to take part in reviews of care planning. However, it was not specified who was responsible for the action plan or what the time frame was for completing the action plan. It was also unclear what actions had already been completed.

We found at this inspection that provider's quality assurance systems were not always effective at identifying where the quality and the safety of the service were compromised. For example, the internal auditing system had failed to recognise the lack of social stimulation or the shortages of staff. This was noticed by people who told us that the management team was reluctant to recognise and to address the issue of insufficient staffing levels. One person said, "The manager thinks there's nothing wrong with staffing levels. I'm not sure how aware the management is about how understaffed they are". The service was using a dependency tool to calculate appropriate staffing levels, however, the dependency tool was not always used correctly and did not reflect people's needs accurately. The issue of the number of new admissions resulting in the insufficiency of the current staffing levels was recognised and noted as a challenge by the registered manager who had left in November 2018. However, this issue remained unaddressed by the service provider.

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

Staff said that there was an open culture within the service as they knew their views and opinions were always taken into consideration by the operational relief support manager. They described him as "approachable" and "exceptionally good".

Throughout our visit the management and staff were keen to demonstrate their practices and gave unlimited access to documents and records. Both the management team and staff spoke openly and

honestly about the service and the challenges they faced.

There was evidence that the staff were valued by the management team. Staff meetings were held on a regular basis to consult and gain feedback from staff. We saw that during these meetings staff were able to discuss topics such as audits, accuracy in documentation, changes in procedures and maintenance issues. 10 at 10 meetings took place every week day with the heads of the departments and the management team. These meetings were aimed at reporting information of daily events, issues and discussing changes in people's needs. These meetings resulted in improved room documentation and care reviews where necessary.
An incentive scheme called 'Carer of the month' had been introduced which involved the presentation of a small gift when a member of staff had gone beyond the call of duty. This initiative had been received well, improved staff's morale and commitment, and was welcomed by staff as a genuine recognition of their efforts.

Staff were aware of the organisation's whistleblowing and complaints procedures. They felt confident in initiating the procedures. The operational relief support manager was aware of their responsibility for reporting significant events to the Care Quality Commission (CQC).

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 Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided to people in a safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems and processes in place to make sure they assessed, monitored and improved their service to ensure people received safe care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People's needs were not met by suitably deployed sufficient numbers of staff.