Belmont Cedar Park Limited

The Cedars Nursing Home

Inspection report

Cedar Park Road
Batchley
Redditch
Worcestershire
B97 6HP

Tel: 0152763038
Website: www.thecedarsnh.co.uk

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
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

About the service
The Cedars Nursing home is service that provides accommodation, nursing and personal care for up to 40 people. At the time of our inspection, 35 older and younger people were living in the home, some of whom may have a physical disability and/or dementia.

The Cedars Nursing Home 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 home is in one adapted building over three floors.

Why we inspected
The inspection was prompted in part due to concerns received about safe clinical care and competencies of staff. A decision was made for us to inspect and examine those risks.

People's experience of using this service and what we found
Risks to people's safety were not always monitored or reviewed. People told us that their care needs were not met in a timely way. People's medicines were not always managed and stored in a safe way. People were not protected from the risk of cross infection. People told us they felt safe from abuse. Staff recognised different types of abuse and how to report it.

People's care was not always robustly assessed and reviewed to ensure it was up to date and in line with best practice. People were not always supported by staff who had the skills and knowledge to do so. People who needed support to eat and drink were at risk of dehydration and malnutrition as records did not clearly demonstrate that people had sufficient to eat and drink. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice.

Staff treated people in a kind and caring way and respected their dignity. Staff strove to treat people as individuals and respected the choices they made. However, people did not always receive care and support in a person- centred way.

People's care was not always delivered in a timely way, people experienced consistent delays in receiving personal care. The provider could not be assured the staff group had sufficient knowledge and skills to support people with end of life care. People were supported to maintain their hobbies and interests. People and relatives did not have clear access to information about how to raise a complaint, where complaints had been received the provider had managed these in line with their policy.

The registered manager was approachable and visible within the service. The provider was aware the registered manager lacked experience in management but had not fully supported them to develop their

role and skills. The audits the provider had in place were comprehensive however they had not been implemented effectively to escalate shortfalls and improve practice. Following our site visit the provider gave us assurances the providers representative would support the home until improvements had been made.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, responsive and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to safe care and treatment and governance of the service at this inspection. Please see the action we have told the provider to take at the end of this report.

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 request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

The Cedars Nursing Home

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team
Two inspectors and an Assistant inspector carried out this inspection on the first day of our inspection. On the second day one inspector and an assistant inspector attended.

Service and service type
The Cedars Nursing Home 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 had a manager registered with the Care Quality Commission. 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.

Notice of inspection
This was an unannounced inspection.

What we did before the inspection
Our inspection was informed by evidence we already held about the service. We also checked for feedback we received from members of the public, local authority and the Clinical Commissioning Group (CCG). We also checked records held by Companies House. 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 of this information to plan our inspection.

During inspection

We spoke with 14 people who used the service and three relatives. We spoke with the five care staff, two nurses and two agency nurses, assistant cook, the chef, the deputy manager, the registered manager and the commissioning and operations manager (who we have referred to as the providers representative within the report). We also spoke with the visiting GP. We looked at aspects of five peoples care records, along with medicine records, nutritional information, handover information, audits of records, medicines policy, activities, staff meeting minutes and complaints.

After the inspection
We spoke with the provider of the service and had a further conversation with the commissioning and operations manager who sent us information regarding templates of governance procedures along with an update of what actions had been implemented following the inspection. We also spoke with the safeguarding officer at the local authority, a quality assurance officer at the local authority and the clinical commissioning group quality and assurance manager.

Inadequate

Is the service safe?

Our findings

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

At our last inspection in May 2017, this key question was rated "Good" at this inspection we found the rating had deteriorated to "Inadequate". This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● People were at risk of potential harm as identified risks were not consistently monitored or reviewed. We found that what staff told us and what the records told us were inconsistent in how people were to be supported to stay safe. For example, whether a person needed support or not to drink.

● There was no clear clinical oversight of people's care and nursing needs. For example, it was not clear who was at risk of losing weight, had sore skin, or who was at risk of dehydration, or who was at risk of falls. Without an overview of people's risks and how these were being managed the provider could not be assured staff were identifying and taking action to meet people's needs and keep them safe from harm.

● The system used for recording people's care and associated risks did not alert staff when required actions were not completed. In addition, we also found there were inconsistencies were staff recorded the information in the computerised system, which meant the provider did not have a clear picture of people's current care needs and the care delivered.

● The provider did not have safe procedures for the storage of COSHH items, such as cleaning chemicals. We found a number of bottles of cleaning chemicals left unattended in communal areas and some people's bedrooms. We also found that doors to the sluice room and cupboards holding COSHH items were not lockable. We asked the registered manager to ensure all chemicals were stored safely on the first day of our inspection, however, on the second day of inspection we found COSHH items remained in communal bathrooms.

● The provider did not have safe procedures for assessing the risk of fire. We were aware that the Hereford and Worcester Fire Service had visited in June 2019, and the provider was working through the shortfalls identified. The provider told us that a private company had previously been sourced to complete fire safety visits and had not identified the shortfalls. The provider understood the risks and was working to resolve these within the set timescale. However, on our inspection, we found a number of combustible items such as papers, boxes and mattresses stored in a cupboard in the eaves which posed a fire risk. These items were removed immediately, and assurances were given that there were no other storage cupboards like this.

● There were a number of windows on the top floor which did not have adequate window restrictors in place. We raised this with the provider's representative on the first day of inspection. On the second day of inspection assurances were given that new window restrictors had been bought and would be installed as priority. There were a number of radiators in bathrooms that were not covered to reduce the risk of potential burns. We found some pipes were warm to the touch which were also not covered. The providers representative told us these areas were being worked through in priority order.

Using medicines safely

● People were mostly receiving their medicines when they should. We found on some occasions people had not been given their medicine as they were asleep. From the records we saw the nurse had not attempted to

offer the medicine later and just destroyed the medicine. It could not be evidenced that the nurse had made checks with the person's doctor to understand if it was safe that the person had missed their medicine that was for their heart.

● We also identified concerns regarding the storage of medicines. For example, there were times when the temperature of the fridge became higher than the recommended safe levels, and checks had not been made to ensure the medicines stored in the fridge were still safe and effective. We also found that when liquid medicines had been opened, they were not dated, to ensure the medicine was being used within its expiry date. We also found thickening powder for people's drinks in a kitchen on the middle floor, and prescribed cream in a communal bathroom.

● Care staff who applied people's prescribed creams did not have documentation in place to accurately record where, how and when it was applied. We saw the nurses where signing to confirm it was administered, but the nurse did not have assurances that the prescribed creams were applied as directed. We raised this with the registered manager who confirmed that prescribed cream charts were going to be implemented to improve the safety of prescribed cream application.

Staffing and recruitment

● We had been made aware prior to our inspection of concerns about safe nurse staffing levels in the afternoon, particularly at weekends when management staff, who were also nurses, were not always in the home. A nurse we spoke with felt there were too many nursing tasks, along with clinical overview responsibilities to ensure the home ran safely during the afternoon shift. We raised this with the registered manager who felt with their support and the deputy managers there was sufficient nursing staff on duty to meet people's needs safely.

● The registered manager did not have a full understanding of people's individual support needs and the skill mix of their staff to ensure they had sufficiently skilled staff to keep people safe. The registered manager told us a training matrix was being collated so they could better understand what skills their staff had and how best to ensure the right skill mix were on duty.

● We received a mixed response from people regarding staffing levels. One person told us, "They check we are okay, the night staff come with drinks and ask after us and check in the night as well." However, most people we spoke with felt there were not enough staff to meet their needs in a timely way. One person said during busy times they would have to wait a long period of time to be supported to the toilet. People, however, told us they had not had an accident or incident waiting for staff.

● Care staff felt people were safe and could not recall incidents or delays in responding to incidents, however they also told us there were not enough staff to meet people's needs in a timely way. Care staff explained most people required two staff to support with safe moving and handling and it was difficult to meet people's needs in a timely way as three staff worked on each floor.

● Staff reported to us that it could be a problem trying to find another staff member within the home, as it was not easy for staff to identify which room staff were in when they were providing personal care. One staff member told us it could take sometime for them to locate staff and said, "I need to listen through the door to see if there are staff in there."

● We saw that staff were visible in the communal areas of the home and were visible within the corridors for those people who were nursed in bed. We saw that call bells were answered promptly.

● From the recruitment records we sampled, we saw that safe recruitment had taken place.

Preventing and controlling infection

● People were at risk of infection from poor infection control practices. We found toiletries such as roll-on deodorant, combs and shavers in the communal bathroom without labels to identify who they belonged too. We saw staff did not always use disposal items where required. Aprons and gloves were tied around communal bathroom cords, which meant staff would not be able to keep these clean. Specimens and swab

samples were also being stored in the medicine's fridge. We raised these issues at the time of our inspection and prompt action was taken to improve infection control practice. These practices meant people were at greater risk of infection.

● People told us their rooms and communal areas were cleaned. We found other areas of the home were clean and odour free. We saw staff wearing gloves and aprons where required.

The above information is 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

● People were kept safe from abuse by staff who knew how to recognise abuse and report this. Staff demonstrated a good understanding of different types of abuse and what approach they would take in the event of any concerns. The registered manager took action and reported safeguarding issues when these were identified.

● The local authority safeguarding team made us aware of a number of safeguarding concerns that had been raised for people living in the home, about the care they received. We discussed these with the registered manager who had submitted notifications about these to the CQC and were working with the local authority to investigate each of these concerns. We spoke with the safeguarding team at the local authority who advised that these concerns were still being investigated.

Requires Improvement

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.

At the last inspection, this key question was rated "Good". At this inspection we found this had deteriorated to "Requires Improvement". This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- The provider had not ensured staff had the right skills, knowledge and experience to effectively and safely meet people's needs. The provider therefore could not be assured people they supported were being cared for in line with safe and best practice.
- The provider's representative told us through external visits by different agencies they were learning what gaps in knowledge the registered manager had, so they would understand how to best support them.
- The management within the home lacked the experience to ensure the staff group were inducted, trained and had opportunities to develop their skills. For example, the provider had put in place a comprehensive induction for new staff, however, new staff were not fully inducted into the service and staff competency checks were not completed to evidence that staff had sound knowledge. Where gaps in knowledge were identified at interview, it could not be evidenced that further support, training and competency checks were put in place.
- There was no overview of gaps in staff knowledge to ensure they attended training courses to upskill and follow best practice guidance. It could not be evidenced that there was a good skill mix of staff on duty.
- Staff told us that spot checks and competency assessments were not robustly carried out to ensure they were applying their skills and knowledge in the right way. We found that the senior staff who checked staff's competency levels had not completed the required training themselves in order for them to assess competencies effectively.
- Relatives gave us mixed views about the way their family members were cared for and told us they were not always confident concerns raised were always communicated across staff teams to ensure a consistent approach.

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

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

- People were at risk of dehydration as systems in place were not effective in ensuring people who required support were receiving this. For example, on the first day of inspection, in the late afternoon, we saw one person who had been nursed in bed had five full cups of juice on the table in front of them. The care staff told us the person could drink independently, however the care records told us the person needed support to drink. As fluid charts were recorded on a computer system we asked the registered manager to show us how much fluid had been recorded. Their chart showed that within an 18-hour period the person had drunk 25mls of fluid. Another person we saw nursed in bed had three full cups of juice, and their total amount

recorded was 395mls within 24 hours. The registered manager confirmed that everyone had their fluids monitored, however, people's daily intake of fluid was not calculated to ensure people were drinking enough, or whether further action would be needed. We spoke with the registered manager about our concerns, who agreed that they could not be assured people had had sufficient fluids to keep them healthy. We asked the registered manager to put measures in place to gain assurances that people were being supported to have sufficient fluids throughout the day.

● On the second day of our inspection the registered manager shared with us people's total amount of fluids recorded over a 24-hour period. It was found that 12 people had had less than 500mls, and only three people had recorded to have drunk over 1Litre of fluid. The registered manager told us they had put paper documents in place for those people who had drunk less than 500mls. Staff reported that this was working better, one staff member said, "You can clearly see when they [the person] was last given a drink, it's a visual prompt to remind us to give the person a drink." We saw on the second day of inspection those who required support had received a higher amount of fluid.

● Staff monitored people's weight monthly, but it was unclear as to whether staff reviewed this over a period of time to be assured people's weight was stable and that any unexpected changes were being actioned.

● Prior to our inspection we had been made aware of concerns raised about staff's knowledge about safe care and management of people's percutaneous endoscopic gastrostomy (PEG). A PEG is a special tube which goes into the stomach through the abdomen wall so that nutrition and fluids can be placed directly into the stomach. Since these concerns were raised we found risks had been reviewed, training received, and safe practice was being monitored. The provider's representative and registered manager continued to review the care plan and were working with the Clinical Commissioning Group (CCG) to ensure the care being received was safe.

This is a breach of Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People, relatives and staff told us the quality and variety of food offered had improved. People said they had enough to eat and enjoyed the food offered. People told us staff knew of their dietary requirements and their likes and dislikes. They told us they were given a choice of food to eat during the day and had access to fresh fruit and snacks if they wanted.

● Where people were on a modified diet staff were aware who required this and what type of diet they needed.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● People and relatives felt involved in the assessment of care from the beginning.

● We saw areas of good practice, where people were supported with their mental health to ensure they had the best outcomes. People also had support to help people get the right equipment for their physical health needs.

● Staff supported people to attend health appointments, opticians and dental appointments, so they would remain well. The GP visited weekly, and people told us they could also see their GP if they became unwell. A visiting GP told us people's healthcare needs were well managed.

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

● The Cedars is an older building and the middle and top floor had many different levels to get to people's bedrooms. The provider had two specialist motorised wheelchairs which enabled staff to safely mobilise people who required use of a wheelchair.

● People had the right equipment in place to meet their needs, such as specialised beds, open plan walk in

showers and hoists.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take 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 with appropriate legal authority. 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 any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

- People told us staff would ask for their consent before undertaking any personal care. People felt staff respected their wishes and listened to them.
- Staff applied the Mental Capacity Act principles in the way they supported people.
- The registered manager worked with healthcare professionals to understand whether people had capacity to make decisions about their care and treatment, and best interest meetings were held where applicable.

Requires Improvement

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.

At our last inspection this key question was rated "Good". At this inspection we found the rating had remained "Requires Improvement". This meant people did not always feel well-supported, cared for.

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

- The provider did not do everything they should to facilitate a caring service. For example the provider hadn't ensured all staff had the skills and knowledge to support people in a safe and effective way.
- People did not always receive person-centred care. People told us they had to wait their turn and could be left waiting for up to three hours. Some people spoke to us about dignity concerns when staff were delayed to support them with their continence care needs.
- The provider's governance arrangements had been ineffective in identifying risks to people's health and safety. People were exposed to risk and potential harm, and when staff had raised concerns these had not been addressed.
- All people we spoke with spoke highly of the staff who cared and supported them. People told us they were happy at the home and considered staff to be considerate and kind. One person told us how staff took their time while supporting them.
- We saw staff supported people in a respectful way, taking the time to explain what was happening, for example, when they were being supported with the hoist.
- There were many positive interactions between people and staff, however these were limited to times where staff were directly supporting people. We also saw people at the home were supportive of each other, and there were many conversations about the news and their life within the home.

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

- Staff recognised what was important to people and ensured they supported them to express their views and maintain their independence. One person told us how they were involved in making a decision about changing bedroom and told us they felt the decision was only made with their full agreement. While another person told us they made their own decisions about how they liked to spend their time. This included choosing what interesting things they would like to do, such as visiting the cinema to watch their favourite films.
- Relatives told us staff supported their family member well and were happy with the care and support provided.

Respecting and promoting people's privacy, dignity and independence

- People told us they were treated in a dignified and respectful way and we saw staff were respectful towards people at all times.
- Relatives told us their family members were treated well by staff and their privacy was maintained.
- Staff told us they respected the person's privacy by ensuring information about their care and support was protected and only shared with their consent.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection, this key question was rated "Good". At this inspection we found the rating had deteriorated to "Requires Improvement". This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- We received mixed reviews about how people's preferences for what time they were supported to get up in the morning. One person said, "You have to wait your turn". They told us how they preferred to get up at 10am but were often supported around midday. Another person told us, "Staff ask us if any of us want to go up [to bed], but you can lose your space. Seven O'clock is the latest I've been up, that's when the shift changes."
- Care staff told us that due to the deployment of staff throughout the floors, it delayed the timeliness of care. Staff felt people could be left waiting for a long period of time for assistance in the morning.
- We spoke with the provider's representative about what people and staff had told us, they explained that staffing levels would be reviewed, and told us they were already looking to increase care staff members. We spoke with the provider following our site visit, who told us their companies' ethos was to provide a good level of staffing, and while they would explore how staff were deployed throughout the home they would ensure staffing levels met people's needs.
- Staff confirmed, and we saw they were kept up to date with people's changing needs. Staff we spoke with felt that the meetings to handover people's needs was useful and sufficient. An agency staff member told us that through handover they had a good understanding of people's needs and what care they needed to complete that day. Care staff told us they were aware of any changes in people's care. This included paper-based fluid charts being brought into place following the first day of the inspection.
- Reviews of people's plans of care did not happen consistently to ensure care was delivered in a timely way. For example, we found one person had finished their course of antibiotics, however the care plan showed that the person was still receiving antibiotics. Staff could not be assured that the correct checks were in place to ensure the person was now well or whether further intervention was required.
- People enjoyed the activities that were provided and felt the balance between activities and quiet time was right for them. Some relatives whose family members were nursed in bed could not be sure they received one to one time with staff. We did not observe the activities staff spending one to one time with people who were nursed in bed.

End of life care and support

- The provider could not be assured nursing staff had the knowledge and skills to meet people's end of life care needs. For example, from nurses training records we reviewed we could not see evidence that they were trained to use syringe drivers. A syringe driver is a small infusion pump used to gradually administer continuous small amounts of medicine such as pain relief or sedatives to help keep people comfortable and pain free. While there was no person using a syringe driver during our inspection, there were people who were receiving end of life care. The provider could not be assured nursing staff had the right knowledge and

experience to know when the person would require these medicines.

Improving care quality in response to complaints or concerns

● The provider had a complaints procedure for people, relatives and staff to follow should they need to raise a complaint. However, people and relatives we spoke with were not aware of this complaint's procedure. We found in people's bedrooms a 'welcome pack' which introduced the home and services available, and also gave information about how to raise a complaint, but the information was not up to date and did not advise of the correct agencies to contact should their complaint not be satisfied internally.

● People and their relatives told us they felt comfortable to raise a complaint if they needed to. However, we found verbal complaints were not escalated and recorded to improve the service. One relative told us when they had raised concerns with staff, this was dealt with, but poor communication across staff teams meant they were not confident their family member consistently benefited from them raising their concerns.

● Where the provider had received formal complaints, these had been responded to in line with the providers complaints policy.

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.

● People's communication and information needs had been assessed. A range of communication tools and aids were used to support effective communication with individuals and ensure they had information in a way they could understand.

Inadequate

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.

At our last inspection this key question was rated "Good". At this inspection the rating had deteriorated to "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; Working in partnership with others

- Management within the home, whilst approachable and caring, did not have the experience to effectively and safely manage the home. The registered manager told us, "I worked as the deputy manager before, but I didn't really do a deputy role, it was more of a name sake really." The deputy manager told us they had not worked in a management role prior to becoming a deputy manager. The provider's representative told us they were aware the registered manager had not previously had sufficient management experience and said, "I am learning now what the [registered manager] does and doesn't know so I can train, support and develop them".
- The provider had put comprehensive audits and checks in place; however, these were not implemented effectively. For example, a medicines audit identified shortfalls, but these were not escalated, actioned or shared with staff to improve practice. Poor practice continued without any learning taking place.
- Staff had raised concerns about poor clinical oversight and the management of people's care, however effective actions had not been taken.
- The registered manager was aware the computerised system for recording people's care was not working as well as expected. They told us records could be stored in different parts of the computerised system, making it difficult to get an overview the person's care and to identify any gaps in information, patterns or trends. It had not been made clear to staff where information was to be recorded so that a consistent approach in record keeping could be taken.
- Staff lacked clear direction and support and not all staff understood their roles and responsibilities. We identified a number of issues such as fire safety, lack of safe storage of COSHH items, poor infection control practices and confidential personal information not being stored securely. These had not been identified within the staff group, management team or by the provider to ensure the service was being run in a professional and safe manner.
- The provider's governance systems had failed to identify shortcomings with the systems in place and care provided. The provider's representative confirmed that they had not completed their own checks to confirm their audits were being used effectively to improve the quality and safety of care and service. They told us that their focus had been in the provider's other services. They recognised more experienced support was required in the home and gave assurances that they would remain in the home until the service had improved. We spoke with the provider after our site visit, who also provided assurances they would be visiting the home, and would be placing their commissioning and operations manager into post until the service had stabilised.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider had lacked oversight that actions agreed at residents meetings were being undertaken. People did not always feel listened too, they told us that 'resident meetings' were held, and promises were made, but changes did not happen. For example, some people told us a shop within the home had been agreed, but they were still waiting for this. People expressed their frustration with not being able to buy items for themselves. Others told us that transport would be arranged so that day trips could be planned, but this had also not happened.

The above information is a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager was open and transparent with all those involved in the service. Feedback from external agencies who had visited the service recently, reported to us an open and honest culture. People and relatives were aware of the recent concerns and were given choices about different aspects of the service. A relative we spoke with appreciated the openness and confirmed they were happy to continue with the care and support for their family member.

● People and relatives told us the registered manager was approachable and caring. They said management were always visible within the home and available to talk to. Relatives told us that where appropriate they were informed of incidents in a timely manner.

● Staff said they worked well as a team and felt supported by management in their role.

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 12 HSCA RA Regulations 2014 Safe care and treatment People did not always receive safe care and treatment by competently trained staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People did not always have sufficient fluids to keep them hydrated

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 were not always supported by staff in a timely way which met their individual preferences.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to ensure the service was well-led.

The enforcement action we took:

The provider is required to submit an action plan each month to evidence improvements in staffing training and competency checks, accurate record keeping and improvements to the environment.