Cookridge Court Limited

Cookridge Court

Inspection report

Iveson Rise
Lawnswood
Leeds
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Website: N/A

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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**

Overall summary

This inspection took place over two days on 05 and 18 May 2015. Both days were unannounced.

At the last inspection in July 2014 we found the provider had breached five regulations associated with the Health and Social Care Act 2008. We found there were not enough staff to provide support to people who used the service, staff members did not receive supervision or appraisals and some training, management of medicines did not protect people from the risk of unsafe care or treatment, complaints were not acknowledged, recognised or handled in accordance with the provider's complaints procedure and the provider had failed to monitor the quality of the service to identify issues. We told the provider they needed to take action; however, we did not receive an action plan. At this inspection we found the home was still breaching these regulations. We also found additional areas of concern.

Cookridge Court is situated in the Cookridge area of Leeds close to bus routes and local shops. The home is registered to provide accommodation for up to 96 people who require personal care, of which the majority are living with dementia. The accommodation is situated

Summary of findings

over three floors that are serviced by passenger lifts. All bedrooms are single rooms with en-suite facilities. There are several communal and dining areas and the home has an enclosed garden area.

At the time of this inspection the home did have a registered manager. However, they were no longer in day to day control of the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were not enough staff to keep people safe and staff support provided was not held regularly and did not make sure competence was maintained. People's care plans did not contain sufficient and relevant information to provide consistent, person centred care and support which included the lack of decision specific mental capacity assessments.

Staff had a good understanding of safeguarding vulnerable adults. However, not all incidents had been reported to the relevant authorities. People were not protected against the risks associated with medicines because the provider did not have suitable arrangements in place to manage medicines safely. Complaints were not investigated and responded to in line with company policies and procedures. The service did not have good management and leadership and people were not given the opportunity to comment on the quality of service and influence service delivery. Effective systems were not in place that ensured people received safe quality care.

Recruitment and selection procedures were in place to make sure suitable staff worked with people who used the service and staff completed an induction when they started work. The applications for the Deprivation of Liberty Safeguards had been carried out; however, people also had their liberty deprived illegally.

People were happy living at the home and felt well cared for. People enjoyed a range of social activities and most had a good mealtime experience. People's physical health was monitored and appropriate referrals to health professionals were made. Staff were aware and knew how to respect people's privacy and dignity; however, this was not always observed.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

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.

There were not enough staff to meet people's needs. The recruitment process was robust which helped make sure staff were safe to work with vulnerable people.

Medicines were not managed safely. Staff sometimes failed to follow the prescribers' direction and people were not given their medicines properly.

Staff knew how to recognise and respond to abuse correctly. However, not all incidents had been reported appropriately. People told us they felt safe but, some people said they did not always feel safe. Individual risks had not always been assessed and identified.

Is the service effective?

Inadequate 

The service was not effective in meeting people's needs.

Staff did not receive regular supervision and appraisal. Staff training provided did not always equip staff with the knowledge and skills to support people safely.

Staff told us they had not completed Mental Capacity Act 2005 or Deprivation of Liberty Safeguards (DoLS) training. We could not see from the care plans we looked at that people had received appropriate mental capacity assessments.

People enjoyed their meals and were supported to have enough to eat and drink. However, on one floor the lunchtime meal was not very well organised. People received appropriate support with their healthcare.

Is the service caring?

Requires Improvement 

The service was not always caring.

Care records did not show how people who used the service and/or their family members were involved in planning their care and support needs.

Staff understood how to treat people with dignity and respect; however, we saw examples of where people's dignity was not respected.

We saw caring interactions when staff provided assistance. Staff knew the people they were supporting.

Is the service responsive?

Inadequate 

The service was not responsive to people needs.

We found care plans did not contain sufficient and relevant information. People were not protected against the risks of receiving care that was inappropriate or unsafe.

Summary of findings

The provider's records did not demonstrate that complaints were responded to in a timely way or appropriate action had been taken as a result of the complaint.

There was a good programme of activity for people to join in with.

Is the service well-led?

Inadequate 

The service was not well led.

Staff did not always feel supported by the management team.

There were no effective systems in place to monitor the quality of service delivery and there was no effective accident and incident analysis carried out and therefore, people were not protected from unsafe care.

People who used the service, relatives and staff members were not consistently asked to comment on the quality of care and support through surveys and meetings.

Cookridge Court

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 over two days, on 05 and 18 May 2015. Both days were unannounced. On the first day the inspection team consisted of four adult social care inspectors, two specialist advisors in dementia/nursing and governance and two experts by experience in people living with dementia and older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day the inspection team consisted of two adult social care inspectors and a specialist advisor in governance.

At the time of our inspection there were 93 people living at the home. During our visit we spoke with 20 people who lived at Cookridge Court, 10 relatives, 14 members of staff, deputy managers, the regional supporting manager and the regional manager. We observed how care and support was provided to people throughout the inspection and we observed breakfast and lunch on all the floors of the home. We looked at documents and records that related to people's care, and the management of the home such as staff recruitment and training records and quality audits. We looked at 14 people's care plans and 10 medication records.

Before our inspection, we reviewed all the information we held about the home. We were aware of concerns the local authority and safeguarding teams had and their on-going investigations at the home. Healthwatch feedback stated they had no comments or had been advised of any concerns regarding the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Inadequate

Is the service safe?

Our findings

People we spoke with told us they felt safe in the home. One person said, “There's only one thing. You can't lock your door at night. I feel really afraid of the dark, and I always lock the door at home. I'd like to know if you could. I'd sleep better if it was locked. I always put my walking frame behind the door. I feel frightened when it's dark and you can't lock the door. I'd just like to lock it at night, that's all.”

Relatives we spoke with said they had some safety concerns. One relative told us, “Mum does not feel safe. She was attacked by another resident four months ago and they did not sort it out for ages. Initially they were moving mum into different rooms but eventually moved her attacker into a different wing. She is still scared if she sees the other lady.” Another relative told us, “They hurt mum by dropping her and I reported it but I don’t think that was passed on.”

We looked at four care plans and we saw there were 13 incidents recorded within the daily notes or care evaluations. One incident told us about a medication error, one told us about unexplained bruising, two about falls, two about assaults on staff by people and seven about people hurting other people living at the home. We asked one of the deputy managers about these incidents and they told us they were not aware of them. We asked for copies of accident or incident reports for these incidents but were told these had not been completed. They said none of the incidents had been referred to the local safeguarding team or to the Care Quality Commission. We could not evidence people had been kept safe at the service.

On day two of our inspection we saw the home had recorded fifteen accidents/incidents from 01 to 18 May 2015. We looked at three incidents that had been recorded on accident forms. Two were about people who were living at the service that had physically hurt each other; the third was a person who alleged they had been pulled out of bed. We looked at the care plan for the person who alleged they had been pulled out of bed. We saw the home had contacted the GP the day after the incident, however, the deputy manager confirmed that no investigation had been completed to look into the circumstances around this allegation.

We spoke to the deputy manager about how safeguarding was reported to the local authority. They told us referral forms were only sent if the local authority wanted the provider to undertake a formal investigation. We found evidence of one safeguarding referral for these three incidents; however, this was stored on the deputy manager’s laptop and had not been filed in the home’s accident folder. We could not see any CQC notifications had been sent or any investigations had been completed to look at how these incidents could be prevented in the future.

Staff we spoke with were able to confidently talk about what they would do should they suspect any form of abuse was taking place. One member of staff said, “Because I know people, I would be able to tell if something was wrong.” Staff said they would report any concerns to the senior and if necessary would speak with the manager directly. One staff member told us, “We get hit a lot by the residents. So many times it’s not worth reporting. I let it go over my head.” Staff we spoke with told us safeguarding training was included in the induction, however, the training records showed that 21 out of 97 staff members safeguarding training had expired.

We concluded the provider had not taken appropriate steps to ensure people were protected from abuse and improper treatment. This is a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment); Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found people were not safe because medicines were not managed safely and appropriately. At this inspection we found the provider had not met the legal requirements.

One person told us they had been taking morphine for pain. They said, “Sometimes I would ask for some but staff would say 'I've got to start the other end, I'll get to you when I can', but they've changed the staff member now.”

We noted on the first floor the medication trolley had been left unattended with the door closed but the key left in the lock. We were told the senior staff member administered the medication on a morning and they began that between 8:00am and 8:30am, we observed medication still being administered at 11:00am.

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Is the service safe?

We saw medication given to one person but staff did not check they took their medicine. We saw them drop one tablet down the front of their clothing and another tablet had stuck to their hand. We advised the staff member that the person had not taken the medication.

Staff sometimes failed to follow the prescribers' direction fully and people were not given their medicines correctly. One person was prescribed medicines for the treatment of behaviour; however, staff were not following the prescriber's instruction, which stated to 'take half a tablet as required during the day for agitation'. Staff were administering half a tablet every night and had been for the previous month. We looked at the person's daily records which showed that during the last month the person had not been agitated. Staff had recorded several times that the person was 'settled'. Another person was prescribed a 24hr transdermal patch to help manage pain. However, records showed on two occasions in the previous week, there was no patch to remove when staff went to apply a new patch.

Another person had two different strength transdermal patches applied each week. A senior care worker said they completed a body map to monitor application and to ensure patches were not applied to the same skin site. However, when we looked at the person's charts we saw staff were only completing a chart when they applied one of the patches; therefore, effective monitoring was not taking place. Failing to administer medicines safely and in a way that meets individual needs placed the health and wellbeing of people living in the home at serious risk of harm.

Some people required their medicines early in the morning. The provider had arranged for night staff to administer medicines to ensure people received the medicines as prescribed, however, we found this did not always happen. On one floor, we saw 10 days out of the previous 28; day staff had administered these medicines. A senior care worker told us this was because night staff did not have time to administer the medicines.

We looked at medication stock and found it was not possible to account for all medicines. Staff had not accurately recorded when medicines had been administered and new stock was delivered. One person's medication administration record (MAR) stated 100 tablets were delivered but another record stated 110 was delivered. The team leader on duty did not know which was accurate. The person's record stated staff could administer one or two tablets for managing pain and according to the MARs, at the beginning of the medicine cycle, the person had 195 tablets and when we checked they had 94 in stock. The MARs did not correspond with the number of tablets in stock because staff had signed 18 times to indicate they had administered tablets.

Some people were prescribed medicines to be taken only 'when required', for example, painkillers and laxatives that needed to be given with regard to the individual needs and preferences of the person. Some people had guidance so staff knew how to give their medicines but others did not so staff were not enabled to support people to take these medicines correctly and consistently. One person was prescribed medicine for managing constipation but there was no information for staff to follow. Other people were prescribed medicines to help manage pain but there was no guidance. Some people could take one or two tablets; however, there was no information to help staff decide when they should have one or two tablets.

The provider's medicine policy stated that where a person had creams and lotions applied, a topical medication application record (TMAR) and body map would be completed. We saw this did not always happen. One person was prescribed two types of lotions. They had a TMAR but no body map for one lotion and no TMAR and no body map for the other lotion. The person had a lotion that was dispensed at the end of February 2015 and there was only a small amount of lotion remaining in the container, which indicated staff were applying the lotion on a very regular basis. However, there was no MAR to show this was being administered and the TMAR indicated it had not been applied for 11 days.

The provider's medication policy stated where a person was unable to self-medicate, a medication record must contain a recent photograph. We saw that seven people did not have recent photographs with their medication record. People's care records made reference to 'Brighterkind' medication policies and procedures. However, we saw staff were using 'Four Seasons' management of medicines policy.

We found that care and treatment was not provided in a safe way for people using the service because there was no safe management of medicines. This is a breach of Regulation 12 (Safe care and treatment); Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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Is the service safe?

We saw there were choking, pressure ulcers, nutrition and falls risk assessments in place in people's care plans and where there had been a history of falls; people had been referred to the falls team. However, some of the risk assessments had not been reviewed on a regular basis. For example, one person's choking risk assessment hadn't been reviewed since January 2015 and it stated clearly in the care plan it should be reviewed on a monthly basis. Another person's choking risk assessment was last reviewed in March 2015; again the plan stated it should be reviewed monthly. In another care plan the choking risk assessment hadn't been signed or dated.

We looked at the care plan for a person who had a pressure wound. The person had been seen by the GP who had prescribed a cream. We found the person did have a care plan to cover skin care; however, their risk assessment for measuring risk of developing further pressure wounds was not completed. We saw a body map had been completed but had no date on it. This map recorded the person had a bruise to their right and left arm and shoulder. We could not find evidence this had been investigated or monitored.

We saw people had personal emergency evacuation plans so staff were aware of the level of support people living at the home required should the building need to be evacuated in an emergency, however, these only contained people mobility needs. The management team were not able to find the completed personal emergency evacuation plans on the first day of our inspection. Care staff we spoke with were unable to locate this information. On the second day of our inspection we were provided with a folder containing personal emergency evacuation plans for each floor and unit. We saw the majority of these plans had been updated on 06 May 2015; however, some of the information was incorrect. For example, one person had moved from one room to another on a different unit. In one file there was no information about the person at all and in another file the room number was incorrect. We saw another person was no longer residing at the home; however, they were still recorded in the file. This means in the event of an emergency there was not an accurate recording of people's whereabouts or who needed to be accounted for.

We saw all environmental safety checks such as water, electrical and gas checks had been completed. However, the last health and safety meeting had been held on 20 September 2013 and the home's risk assessment file contained environmental assessments dated 4 November 2013.

We found monthly and weekly fire checks were up to date and were being reviewed monthly by the deputy manager. We saw the fire risk assessment was dated 19 September 2013 and bedroom risk assessments 05 September 2014. We could not be assured the home was safe as these assessments were out of date.

We saw regular fire drills were being completed for day staff and records kept of who attended and the outcome of the drill. We spoke with the maintenance person about drills for night staff. They told us, "I would only do these if I was asked to by the manager. They haven't been done for quite a while." We could not see any records of fire drills completed at night. We spoke with the regional manager about this who said "I think the night staff come in for the day staff drills."

We found all weekly and monthly checks were in place ensuring the safety of items such as of wheelchairs, window restrictors and nurse call bells.

We found that risks were not fully assessed for the health and safety of people who used the service and the environmental risks had not been updated. This is a breach of Regulation 12 (Safe care and treatment); Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found people were not safe because the provider had not taken appropriate steps to ensure that at all times there were sufficient numbers of staff. At this inspection we found people were still not safe because the provider had not taken appropriate steps to ensure sufficient staffing levels.

Relatives we spoke with told us they thought there were not enough staff. One relative told us, "There aren't enough staff. It takes a while to answer call bells." Another relative told us, "I live away, but I often ring in the week to have a chat. Quite often I have to ring several times, because I can't get through to the main phone, no-one's there to pick up." One relative said, "There have been a lot of staff changes and there doesn't seem to be enough of them. I'm not sure if they would cope if there was a fire. I asked a carer what the procedure was but I'm not sure she knew it." Another relative said, "There have been four matrons in 18

Is the service safe?

months since mum has been here. The staff are very good but they don't know what they are doing. They want to do a good job but don't have the training. We don't know who the team leaders are. Matrons should be on the floor, not in the office. Staff don't feel they can ask for help." One relative said, "They don't have any handovers. Over Easter they were unable to get medicines from Boots for mum. My sister had to ring 111 to get a GP. Cover is minimal over weekends and Bank Holidays."

We saw in relatives' meeting minutes from 08 May 2015 that staffing levels were given as ground floor, five care staff and one senior staff member, on the middle floor, four care staff and one senior staff member and on the top floor four care staff and two senior staff members. It was recorded in the minutes, "Some relatives feel as though BrighterKind need to take more action with staffing levels, this is due to relatives who don't feel their family members have the amount of attention they should, especially on court lounge, there is only one buzzer and staff to not always check."

We noted from the complaints we reviewed that concerns about staffing levels had been raised by relatives in October and November 2014.

The staff we spoke with expressed concerns about the poor staffing levels at the home. Three staff members told us they often saw care staff crying on duty because they felt so overworked and under pressure to perform well when there were so few staff. One staff member told us they were the only staff member on duty for one shift with a senior worker and this happened over a three day period. Other staff members told us they would often be left short staffed especially over a weekend. Some staff members told us, "When staff are allocated to work on this floor, they go off sick and this isn't reflected in the rota numbers." Staff we spoke with said sickness was an issue, more frequently over a weekend and they felt it wasn't being dealt with appropriately. We asked staff if they had raised their concerns with the management team. They told us they had mentioned the issue to the managers on more than one occasion but felt they weren't being listened to. They said the care and treatment of people who used the service was at risk because staff didn't have the time to spend with people and often didn't have time to follow through with requests from people. This was reflected by a relative who told us they had asked for a piece of toast for their family member but it never appeared. They asked for a specific piece of furniture and this too had not appeared. The relative we spoke with told us they felt the home was too slow to respond to requests.

A member of staff said, "Staffing is a bit low sometimes." One member of staff said "There were 14 people to get up when I started my shift today, and of those three people needed the assistance of two people." They said that four or five people had wanted a bath or shower that morning. They said there was one member of staff doing breakfast that was making drinks serving hot food, cereal and making toast. That left three members of care staff to get people up, washed and dressed and the senior staff member would be giving out medication. They said it was not unusual for people to wait 15 minutes for their buzzer to be answered. Other comments included, "We could do with more staff, but they would need to be staff that want to do the job, and not people who just treat it like a job", "When people are sick they get cover, it's usually weekend's people phone in sick" and "You might have to wait a few hours for them to get here."

On a number of occasions during the morning, we went looking for staff in the corridors on the first and second floors. Quite a number of people appeared to stay in their rooms. It was often difficult to find staff for some time. Despite the large influx of staff around lunchtime in the dining room, there appeared little interaction or support and response was disorganised. There were still few visible staff during the afternoon.

We noted on one occasion a call bell was ringing for nearly 15 minutes and the person's bedroom door was open and they were laid on their bed uncovered, just wearing a pyjama top and incontinence pants. We saw a member of staff writing notes at the nurse's station, the person did not respond to the buzzer. We then saw the senior staff member go into the person's room next door to administer medication; however, the senior staff member did not check the person. Eventually, the activity co-ordinator went to check the person but could not rouse him. She told the senior staff member she couldn't rouse him who said, "He's always like that on a morning." We checked the person's care plan and couldn't see any mention of this, other than sometimes he sleeps a lot. During this time his door was left wide open. A member of staff came after nearly 15 minutes and closed the door.

Inadequate

Is the service safe?

One person we spoke with told us, “They look after me well. The staff are very good but a bit slow when you call for them.”

We were told by the deputy manager the home used a system to make sure the staffing levels were safe. The system assessed the acuity of residents’ needs. The model suggested that currently 18.6 staff should be available to staff the home during the day. The actual number deployed showed that frequently staffing levels fell below this level. There was also wide and unexplained variation between different days of the week. For example, on the middle floor, week commencing 06 April 2015 the staffing level during the day was 11 staff members for four days, 10 staff members for two days and eight staff members for one day and during the night 16 staff member and the week commencing 20 April 2015 the staffing levels during the day were 54 staff members and during the night seven staff members. The management team told us this was not correct but were unable to show us evidence to corroborate this.

We concluded the provider had not taken appropriate steps to ensure sufficient numbers of staff were deployed in order to meet people’s needs. This is a breach of Regulation 18(1) (Staffing); Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment records for staff members. We found recruitment practices were safe and relevant checks had been completed before staff had worked unsupervised at the home. Staff told us they had filled in an application form and attended an interview. This helped to ensure people who lived at the home were protected from individuals who had been identified as unsuitable to work with vulnerable people. Disciplinary procedures were in place and this helped to ensure standards were maintained and people kept safe.

We saw some people had photographs of themselves outside of their bedroom and people’s bedrooms had been personalised to reflect their taste and personality. We saw the home was clean. However, we noted there was an odour throughout the second floor and one relative we spoke with told us it was the first thing they noticed when their family member moved into the home. We saw there were no hand sanitisation stations around the home except for one in the main entrance and the entrance to the first floor.

Inadequate

Is the service effective?

Our findings

At the last inspection we found the service was not effective because the provider had not made sure that staff received appropriate professional development, supervision and appraisal. At this inspection we found the provider had not made any changes to ensure staff received professional development, supervision and appraisal.

Several people told us they thought the staff were competent.

During our inspection we spoke with members of staff and looked at staff files to assess how staff were supported to fulfil their roles and responsibilities. Staff told us they had not had supervision since 2012 or in some cases not at all. None of the staff could remember having had an appraisal or a personal development plan. One staff member said they had not had any one to one supervision and they had not had a six month review. They said there had been a staff meeting a few weeks ago but supervision tended to be in a group setting. One person said, "I'm not sure how they know if I'm doing a good job but it would be good to be told." They also said the senior staff member did thank them.

Staff files we looked at showed supervision had not been carried on a regular basis. For example, one staff member's file showed they had not had supervision since 2012 and another staff member's file showed no record of supervision, having started working in the home in 2012. We saw other staff files showed one or two supervisions had taken place in 2014 or 2015 but these were on generic subjects. For example, one staff file showed supervision had taken plan in May 2014 and was about pressure care. In the staff files we looked at the last appraisals we could see were for November 2012. The regional supporting manager told us they had a supervision schedule for 2015, however, they said staff had not received individual supervision or an appraisal. They said they had asked staff over the past two weeks and staff had said they had not received either.

The regional supporting manager gave us a copy of the action plan they had implemented following the last Care Quality Commission inspection. The document stated 'provide 1-1 and group support to staff to enable them to understand their roles and responsibilities and commence the annual appraisal for all staff'. The action plan was undated and we could not see any action had been taken.

We looked at the provider's staff supervision and appraisal policy, which stated 'all staff, including volunteers, shall play an active and proactive part in the staff supervision process. Supervision shall take place every eight weeks or six times per year'. The policy also stated 'key elements to be covered during supervision sessions include caring skills and competence, communication skills, reliability and attendance, general conduct, attitude, professionalism/ appearance, reaction to workload, leadership, initiative and record keeping and documentation. 'In addition to regular supervision meetings, a formal appraisal should be held with each employee once annually'.

We looked at the monthly visit report carried out by the regional supporting manager in April 2015. This stated, 'supervisions and appraisals are commenced as a priority. This will be requested by impending CQC visit'.

We concluded the provider had not taken appropriate steps to ensure staff received appropriate ongoing or periodic supervision and an appraisal to make sure competence was maintained. This is a breach of Regulation 18(2) (Staffing); Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the day of our inspection we saw some staff were attending health and safety, food hygiene and fire safety training. We looked at staff training records which showed staff had completed a range of training sessions, both e-learning and practical. These included infection control, moving and handling and health and safety. However, we saw some of the training had expired for some staff. For example, 14 members of staff had not had infection control refresher training. Staff told us they had been trained in what to do in an emergency; one person said they thought the bit about CPR was really good. They also said they had just completed dementia training and the training had helped them to understand the different types of dementia. We were told there was lots of training, staff were notified by letter, and information about courses was put on the staff room wall. We noted some non-mandatory training had been completed which included behaviours that challenge; dementia awareness; and customer care. However, staff told us they had not received training on managing behaviours that challenge. This meant people were at risk of harm because the service had not taken steps, which ensured staff had the training and skills to de-escalate situations.

Inadequate

Is the service effective?

The regional supporting manager told us the deputy manager monitored staff training through a training matrix.

We were told by the regional manager staff completed an induction programme, which included information about the company and principles of care. We looked at staff files and were able to see information relating to the completion of induction.

One person who used the service we spoke with told us, "We went through a period with untrained staff but its better now. They are still not trained but they are better behaved."

Care plans we reviewed did not have decision specific mental capacity assessments recorded.

Four care plans did not contain a consent to care form, although people had all been deemed to lack mental capacity, we saw no evidence that capacity assessments had been carried out for these people. We looked at a further three care plans around how people were able to make choices and decisions. We saw care plans were in place for 'consent and capacity' for each person. The care plans contained consent forms signed by family members. However, we could not see an assessment of capacity had been completed to ensure the person could not consent for themselves. The care plans had not always been reviewed monthly.

One care plan we looked at told us the person had 'variable capacity'. There was no mental capacity assessment document in place to show how this decision had been determined. We also found the care plan was generic and did not consider capacity for specific decisions. This meant the support offered did not meet the guidelines set out in the Mental Capacity Act 2005.

In one care plan we looked at we saw on 08 March 2015 they had been assessed as having capacity to receive personal care. They had been diagnosed as having mild dementia. The next entry, which was not dated or signed, stated the person had 'dementia that is very progressed and are not able to consent'. There was no evidence an assessment of their mental capacity had been carried out to determine whether the dementia was in fact very progressed. This meant the rights of the person to make a decision had been put at risk because the service had not produced any evidence the person's dementia had been assessed.

Another person's care plan told us the person had the ability to make decisions about everyday life. In the evaluation on 15 February 2015 it clearly stated the person had 'no capacity'. There was no evidence to show how this had been assessed. The care plan stated the person had an alarm mat and cushion sensor that alerted staff when they moved. There was no evidence to show this had been decided in the best interest of the person or they had been involved in this decision. No Deprivation of Liberty Safeguards (DoLS) application had been made by the home in respect of this continuous supervision. The deputy manager told us they had not contacted the local DoLS assessor for advice on this matter.

The applications for the Deprivation of Liberty Safeguards had been carried out appropriately. This is a breach of Regulation 13; Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with four staff about their knowledge around mental capacity and DoLS. Staff were unsure about how to assess mental capacity and said they did not understand the DoLS process and would leave this to the manager. One staff member told us, "I find it really complicated and confusing." Staff told us they had not received training on mental capacity or DoLS. The training records showed that 43% of staff had completed risk, restraint and capacity training. We asked staff what they would do if people refused personal care, one member of staff said, "If someone was wet I would try again 10 minutes later, but if they still refused I would just have to change them because you can't leave them wet." This meant the rights of people who used the service were at risk because the service had not taken steps which ensured staff had the received training to understand mental capacity and what would constitute a deprivation of liberty.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards which provide legal protection for vulnerable people if there are restrictions on their freedom and liberty. At the time of our visit five people at the home were subject to DoLS. The deputy manager told us 15 DoLS applications had been submitted. Nine had been granted and six remained outstanding. One application related to a person not being able to leave the building and the others were in relation to providing personal care. We saw examples of

these applications. We found DoLS authorisations had been applied for and granted for some people, however, we could not see mental capacity assessments relating to those applications.

The care plans we looked at did not contain appropriate and person specific mental capacity assessments, which would ensure the rights of people who lacked the mental capacity to make decisions were respected. This is a breach of Regulation 11 (Need to consent) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were offered choices of drinks and snacks throughout the day, which included fresh fruit. We saw one person request a drink that wasn't readily available and staff went and got this drink for them.

We observed lunch in all the dining areas. We saw tables were nicely set with table clothes, napkins, condiments and wine glasses. However, one person told us, "The glasses are a nuisance, we don't normally have them." Staff offered people visual choices to aid them to pick a suitable meal. Meals were well presented and people enjoyed the social occasion. Staff interacted in a kind and dignified way with people and offered assistance where needed.

However, we observed the middle floor service was chaotic, the kitchen area was disorganised with no structured distribution process. There was no leadership or plan around who was doing what. We saw one person take the french bread served with their soup, opened the window and threw it out. Staff did not notice this. One staff member was not aware of the flavour of the soup and they handed out the bread roll when the soup had been taken away. We saw the sandwich platter was placed on the sink draining board and we observed a number of staff washing their hand in the sink. The tables were served haphazardly resulting in some people getting food and others being forgotten One person said, "They always forget this end, we often don't get any. But complaints don't get you anywhere." The staff did not always offer assistance with eating. People were able to have meals that were not on the menu.

We spoke with the acting chef who told us, "The food is amazing and they have a big big choice." They said they were aware of people's likes and dislikes and if people had any allergies. There was always plenty of food and the kitchenettes on each floor were well stocked. Feedback was given by the care staff and through a book on each floor of what people had liked and not liked. They told us, "I am informed if people are losing weight and I send finger foods and use thickener for the milkshakes." They also told us menus had previously been chosen by people living in the home. They did say the home was overspent on the budget; however, this had not affected the amount and quality of the food.

On the second day of our inspection we asked to look at the menus for the week. The supporting chef told us they had not been formulated yet as they had not been on duty over the weekend to prepare them. A menu was available for people to view but the supporting chef said this would change when they had evaluated the stocks that were available. We looked at menus for the previous week and found that choices were offered and the menu was varied. The supporting chef told us one person living at the service needed a 'soft' diet. They did not know any further details about the type of consistency needed and had asked care staff to provide this information. The also told us they were not aware of anyone who had diabetes.

We had a mixed response when we asked people and relatives about the food. Some said they were satisfied with the food and some said the food was not very nice. One person said, "I've had my lunch. It was tasty but not enough. People are trying to make money out of nothing." Another person said, "The food's not bad. It's edible. It's all different from what I'm used to. Things you fancy, they don't have. It's not always what you want." One person told us, "There's nothing I would change except the food. The food was alright to start with but it's gone downhill. If they've had to cut it down for financial reasons, what can you do. We used to have more cooked meals. You don't expect sarnies for Sunday lunch, do you?" One person we spoke with said they did not fancy the sandwiches or the pasty. A member of staff brought soup. They said, "I'm not eating that." However, one person told us, "The food is lovely. They bring it to your room if you want. There are always a couple of choices."

We noted the food on the second floor looked unappetising and insufficient. The soup was tomato and pepper, but it was a very strange colour and texture (looked curdled) and cold. People who selected sandwiches received two quarters of either ham, egg or cheese sandwich, with some crisps. The other option was cheese pasty with beans, which looked a little more appetising, and some people had more than one of the options.

Inadequate

Is the service effective?

We saw where weight and dietary intake was an issue, there was evidence the home had sought advice from external agencies such as the persons GP or the dietician. However, we saw in one person's care plan they should have been weighed weekly but we could not find any evidence they had been weighed since the 18 March 2015. We saw a weight audit chart for March 2015 and out of 27 people who had been weighed, 12 of them had lost weight. We asked for the most recent weight chart but the management team did not provide this on the day of our inspection. This meant people were at risk because the service had not taken steps to monitor people's weight.

The fluid charts we looked at for the 02, 03, 06 and 11 April 2015 had been totalled and each one we looked at recorded people having had over a litre of fluid a day. This meant people were being protected from the risk of dehydration.

Staff told us the food had got a lot better, people were able to choose what they wanted on the day, for example, the lunchtime meal would be soup and or sandwiches with a choice of two puddings and for the evening meal they would have a choice of two meals and two puddings.

We looked at food surveys and found these had last been completed in 2012. We spoke with the supporting chef. They confirmed that no recent surveys had been completed. We saw that dietary notification forms had been completed and were available to kitchen staff. This detailed people's likes and dislikes and had been completed in April 2015.

We saw the provider involved other professionals where appropriate and in a timely manner. We spoke with a visiting health professional who told us, "The home had improved with the pressure care and referrals were appropriate."

People who used the service had access to a wide range of health care professionals. Staff told us they had a good relationship with local GP's and district nurses. We saw staff recorded when health professionals visited people however; care plans were not always updated to reflect any changes made. We saw the home used the local mental health services on a regular basis and the optician was visited on the day of our inspection.

People we spoke with said staff were good and looked after them well. One person told us their wounds were dressed every other day. People said the doctor and chiropodist visited regularly. At lunchtime we observed one staff member supported a person return from a hospital visit.

There was no signage evident to direct people towards the toilet, bathrooms or shower rooms. This meant people who had memory problems, but were otherwise independent relied on staff to support them in their personal care.

Requires Improvement

Is the service caring?

Our findings

We were told the manager assessed people before they came to Cookridge Court; the assessment was then shared with staff so they knew how to care for people. These were evident in the care plans we looked at.

Staff we spoke with had a good understanding of people's needs and were able to tell us about people and a little about their life history. However, we saw very little about people's life history recorded in their care plans. Some of the staff we spoke with didn't have a good understanding of the needs of the people they had been supporting because they were new to the floor and had previously worked in different part of the home.

People looked well cared for and most people were tidy and clean in their appearance. However, we did see one person with wrongly matched clothes and some people's clothing was badly stained with spilt fluids and food. Staff we spoke with told us they were confident people received good care, all staff said how they supported people to make choices and there was a strong emphasis on person centred care. We saw people were able to express their views and say how they wanted to spend their day. The premises were spacious and allowed people to spend time on their own if they wished.

We observed staff speaking with people in a pleasant and friendly manner. People we spoke with and most of the relatives were very complimentary about the care given by staff. Staff we observed knew people by name. Whilst we were speaking with one person, a member of staff came in to the room and chatted to them and asked if they would like her light off. They said yes please. The staff member told us they did not like bright lights. The person said, "He's a darling." Comments from people included, "They're very good" and "Some of them are good, but some of them are just doing a job, you know." One relative we spoke with said, "Some of the staff are nice, others are a bit functional." Another relative told us, "Dad has had a lot of urine infections and has been admitted to hospital a few times. Each time they have told me he is dehydrated and has to be put on a drip. I don't think staff are managing his catheter properly and that is why he is getting the infections."

Our review of care plans did not show clear, consistent evidence of how people who used the service or their relatives were involved in the development of them. None of the people or relatives we spoke with knew about being included in discussions about care plans. One person said, "I don't like it. I don't know what's going on about sorting home care for when I go home. I didn't know the home are supposed to talk to you about care at home or how I was going to get home." One relative said, "I thought someone would come and talk to us when she came in about her care. We've had to ask everything. Nobody's spoken to me. I want to see the care plan this afternoon."

One relative we spoke with told us they had a phone call from the home informing them they had to move their relative to another room on another floor. The decision was based on complaints made by relatives of other people. The relative we spoke with was not very happy with this decision and spoke to the manager about it. No evidence regarding the complaints could be produced. The manager then told the relative it was because of deterioration in their family member's dementia. The relative we spoke with had been told only a few days before their family member was progressing very well. We could see no evidence in the person's care plan an assessment of their dementia had taken place. The home had made the decision without any formal consultation with the family and the decision to move the person was made on the day they moved them. There had been no indication prior to this any concerns had been raised.

The staff we spoke with told us they felt people who used the service were treated with dignity and respect.

One relative told us, "There are lots of laundry mix ups, particularly during the night. Dad's shoes have gone missing and so have his glasses." Another relative said, "They don't always check mum is wearing pads even though I have reported it. I have three times found tablets on the floor, which are not mums and they keep mixing her clothes up. Sometimes she is left without bedding all day. Look, no pillow today. I haven't seen her care plan since she moved in."

On the second day of our inspection we noted that one person did not have any items of clothing to put on their bottom half. A staff member had been to the laundry and was unable to locate the appropriate items of clothing. This person also did not have a dressing gown to put on. This person went for breakfast in their nightgown and a cardigan.

Inadequate

Is the service responsive?

Our findings

Some relatives we spoke with said there was a care plan, however, others didn't know. One person who used the service said, "You don't get told a great deal, so I don't ask. I can't remember a care planning meeting when I came in. [Name of staff member] did ask what were my hobbies and favourite foods."

We spoke with staff about how they cared for the people on their floor. Staff were knowledgeable about people's needs and how care should be delivered. All staff said they had access to care plans so they could update themselves.

Care plans we looked at had sections for: the initial assessment; accident record; nutritional needs; skin integrity/tissue viability; psychological; emotional and sleep needs; communication; behaviour; cognition; breathing; altered state of consciousness; my journal, which contained information about for example activities; my preferences; and medication. We found some of the sections of the care plans were not completed appropriately, were out of date, inaccurate or had sections that were blank or incomplete. For example in one person's psychological, emotional and sleep needs care plan, information just related to the person's sleep patterns. We spoke with one of the deputy managers about this who said, "Yes we've recognised that staff don't understand how to fill this in." We saw people had booklets in their care plan called 'My Life, My choices'. Three care plans did not have these completed. This meant staff did not have accurate and up to date information about people's care and support needs to enable them to deliver care effectively and safely.

We were told the home had introduced new care plans; however, not all the relevant sections had been completed. Staff told us they thought the new care plans were good but they had not had any training on them. Care staff said that whilst they looked at the care plans the only involvement they had was writing the daily reviews, which were kept separately and then archived into the care plan. We were told each person had a photograph attached to their daily record so it was easy to identify people. However, none of the care plans we looked at had a photograph of the person.

We found not all the care plans we looked at were reviewed or updated on a regular basis. We looked at one person's care plan who was admitted to the home because they had fallen a lot at home. We saw an initial falls assessment had been completed on 04 October 2014; however, this had not been updated since. A plan of care about mobility was in place but had only been reviewed in December 2014 and again in May 2015. We noted the person had been seen by a district nurse in November 2014 as they had a wound. We found the person did have a care plan to cover skin care; however, their risk assessment for measuring risk of developing further wounds had not been completed since 21 November 2014. The care plan had been reviewed in December 2014 and in May 2015.

We found not all the care plans we looked at recorded accurate information. We looked at a care plan for a person who displayed behaviours that challenged. Their care plan stated they had no issues with this type of behaviour, however, the daily notes showed this was not the case. This meant there was no clear plan for staff to follow when helping support this person. We looked at another person's behaviour chart and saw this had been completed but there was nothing in their care plan to say when or why this was to be used. Where it was noted people had behaviours that challenged, the care plans did not state how the behaviour was to be managed and what staff would need to do to de-escalate the situation. We asked one staff member how they would manage people's behaviour; they told us they didn't know much about people on this particular floor because they didn't normally work there. They normally worked on another floor and could not answer the question. This meant people were at risk of harm because staff didn't have an understanding of how to manage people's behaviour.

One person's care plan contained a diet notification sheet. This stated the person required a 'soft diet'. We looked at the nutrition care plan and found it had no name or date on it. The care plan did not detail that a soft diet was needed or that any specialist support had been sought from a speech and language therapist. We saw a choking and oral health risk assessment was in place and these should have been reviewed monthly but had only been completed on 15 December 2014 and 08 April 2015. We spoke with staff about why this person needed a soft diet. Staff told us they thought it was due to the person's teeth and their inability to chew. We were not able to find an assessment that had been completed by a dentist.

Inadequate

Is the service responsive?

In one care plan, staff had ticked a box in the mobility part of their plan to say the person didn't have diabetes when in their assessment it stated clearly they had type two diabetes.

One person was prescribed Lithium and we could not see any documented advice for care staff which would enable them to monitor for signs of any adverse reactions. We were unable to locate a medication care plan for this person. We were told by staff the district nurse visited the person every three months to check the person's lithium levels and the district nurse phoned the day before to instruct staff not to give the person their lithium that night. We asked staff and the deputy manager how they ensured appointments with the district nurse were not missed, we were told, "The GP surgery is very good they would never miss." We were concerned that the home did not have a process in place to identify if the visit was missed.

We saw in another person's care plan a medical diagnosis of a dementia related illness, however, we were unable to see how this affected the person other than the person could become disoriented at times and a little confused. We did see evidence that a referral had been made for the person's mental health to be assessed but we could not see why the referral had been made.

We were not always able to clarify why a person was prescribed a certain medication, for example, we saw one person was prescribed anti-depressants but we could not see information in the care plan about the person having a diagnosis of depression. This would help staff monitor for signs of depression.

We found not all the care plans information was implemented. We looked at a care plan for a person who had been referred to the local falls clinic as they had fallen multiple times. We saw on 05 March 2015, staff had recorded the person should be checked every 15 minutes at night as this was the time when most falls occurred. Staff provided us with night check records from 27 April 2015 to 04 May 2015. These did not show the person had been checked at such frequent intervals. It showed they had been checked every two hours. We saw the person had a care plan to cover their mobility needs, which had been reviewed monthly and a falls risk assessment was in place but this had not been evaluated since 15 December 2014.

Another care plan we looked at was for a person who had lost weight. We saw the GP had been contacted and advised to weigh the person weekly on 19 March 2014. We saw the care plan had conflicting information. In one part it stated to weigh the person monthly and in another it stated weekly. We spoke to two staff members who told us it should be done weekly. The weight records showed they had been weighed on 20 and 27 March 2015 and on 3, 10 and 24 April 2015. This showed the instruction to weigh weekly was not always followed.

We found that people had care plans recorded for 'cognition'. We asked staff what this meant. Not all staff understood what this was. Two records we saw stated 'staff should provide cognitive stimulation'. It was not clear what was meant by this instruction and staff could not tell us what it meant.

We found that all the care plans we looked at were not updated on a regular basis, some sections were not completed appropriately or were inaccurate. This meant we could not be sure people were receiving appropriate care and support to meet their needs. This was in breach of regulation 9 (Person-centred care); Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found people were not safe because the provider did not have effective systems in place to identify, receive, handle or respond appropriately to complaints. At this inspection we found the provider still did not have systems in place to identify, receive, handle or respond appropriately to complaints.

One person said, "I don't have any specific grumbles or worries, so I don't know who I'd talk to if I did. I don't get involved in stuff." Another person said, "[Name] is the new manager. She's very nice, but I think I could talk to [staff member's name] about any worries because I know her better." Another person we spoke with said, "Complaints don't get you anywhere." One relative told us, "Dad's glasses, shoes and clothes have gone missing but nobody could help when I complained."

Staff told us if a person complained to them they would tell the manager, staff said they thought they would take it seriously.

We saw there was no systematic monitoring of complaints and the procedure were not always followed. We found the records to be disorganised, which made tracking complaints difficult.

Inadequate

Is the service responsive?

We found since September 2014, the home had received twelve complaints. We saw three had been dealt with following the company's policy and had response letters to the complainants detailing actions to be taken. We found six of the complaints had no follow up letters so we could not evidence the complaints had been managed appropriately. We found a further three complaints had no detail about the actual complaints made. We saw acknowledgments letters had been sent to complainants; however, we could not see the actual complaint or any follow up information. Responses to complainants were not always appropriate. For example, in response to one complaint in October 2014, it stated 'I acknowledge your letter of 11 October 2014 describing your appalling findings on your visit to your mother last Saturday. Staff have already been told that they are expected to improve practice or leave. (shape up or ship out). Clearly this has not been effective as good practice seems to be for weekdays only'.

There was no analysis of complaints or systems to track progress. We saw five complaints that were currently outstanding. These ranged from August 2014 to March 2015. For example, we looked at a complaint made on 22 March 2015 following a meeting with family members. We saw an acknowledgment letter had been sent but we could not see any minutes from the meeting or any follow up information. Another example, we looked at a complaint logged on 4 November 2014. We could not find evidence of an acknowledgment letter, investigation or conclusion to the complaint.

The registered person did not have effective systems in place to identify, receive, handle or respond appropriately to complaints. This was in breach of regulation 17 (Good Governance); Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw activities for the week commencing 04 May 2015 were displayed in the entrance to the home and on each floor. They included garden walks, games, church, exercise, entertainment by an external entertainer, walks to local café, cinema and a visit by a dog for people to pet. We saw one member of staff circulating in one of the lounge areas doing crafts on a one to one basis.

We observed in the second floor lounge people watching 'Mamma Mia' and 'Love Me or Leave Me'. People appeared to enjoy the films and staff were encouraging people to sing along with the music. One person commented, "I really enjoy a sing along. Its good fun." However, during the morning we observed there were not enough seats for everyone to sit and watch the film. Staff got additional seating from the dining room; this made the room very crowded.

We observed an exercise session, which consisted of lively music and movement activity. Most people appeared to be really enjoying the activity. We noted there was meant to be singing in the second floor lounge, but we did not witness this and did not see any activity in the first floor lounge.

People told us the home enabled them to maintain relationships with family and friends without restrictions.

Inadequate

Is the service well-led?

Our findings

At the last inspection we found people were not safe because the provider did not have effective systems in place to monitor the quality of service delivery. At this inspection we found the provider still did not have effective systems in place to monitor the quality of service delivery.

At the time of our inspection the service had a registered manager. However, they were no longer in day to day control of the service. The service had two deputy managers and a regional supporting manager, who were overseeing management of the home.

We observed during the inspection that some staff seemed unsure about their role and responsibilities. We did not see senior care staff providing any direction or instruction. For example, the lunchtime organisation was poor despite a senior care member staff being there. One relative we spoke with said, "There is no leadership but [name of deputy manager] is good." Another relative said, "There were problems at the beginning but [registered managers name] did an excellent job and sorted them out. Now she's gone I don't want things to drift back." One relative told us, they were happy the manager had left due to the manager saying they had never warmed to them. Another relative said, "We're looking for somewhere residential. It won't be here. It looks good, but it's all fur coat and no knickers. It looks very nice on the surface, but it's the care that matters, isn't it? I live away and I have to go home soon. I'm really worried. I can't bear to think about it. This is the hardest thing I've ever done."

We spoke with staff about how the home was managed. Some staff said the deputy manager was friendly and approachable. One staff member commented, "The manager's door is always open. I can go to her and I know something will get done." Another member of staff told us, "The manager always listens." One staff member said, "I like it here, I just wish we had more time to spend chatting to people, we can't because there's just so much work to do." The staff told us there was a nice atmosphere and would have no problems speaking to the deputy manager if they had any concerns.

However, some staff told us the service was not inclusive and things changed without staff being consulted. For example, the way the rota was organised had been changed without staff being asked for their views or even told the rota was being changed. We were told staff did not always get to find out about things, they said they did not know the previous manager was leaving. Staff felt they couldn't talk to the senior managers because they had little interest in what they had to say. One staff member told us, "The senior manager treats us badly and has no respect for us." Another staff member told us, "They [senior staff] never praise us they just tell us what we are doing wrong, it's demoralising." Another staff member told us, "People are leaving and I can't blame them. Relatives can see what is happening and feel sorry for us because of the amount of rushing around we have to do."

Staff told us when they had expressed their concerns about the poor staffing levels; they were met with a poor response from the senior management team. One staff member told us the senior manager would often just shrug their shoulders and tell staff 'if you don't like it here there's the door'.

We asked for the audits that were completed as part of the home's quality monitoring. We were shown a copy of the service quality audit, however, this was not dated. The audit evaluated fourteen areas of the service. We saw the home scored 3% on this audit as 304 questions had not been completed.

The section on 'management' scored 73%. We looked at the answers submitted under this section and could see the results were inaccurate. The service had scored the home as being 'compliant' with complaints, CQC standards, auditing and governance. Evidence seen during the inspection did not show these areas were being met.

We saw a 'quality indicator' report form March and April 2015. We found on both the March and April 2015 report some areas had not been completed in full. For example, the record from April 2015 showed two people had pressure ulcers being cared for by district nurses, 18 people had been treated for infections, nine people had lost over 2kg in weight and 18 people had fallen. We could not see detail that told us what actions were being done to address these areas. The section that recorded why people had not been weighed was blank. Another example, in March 2015 five pressure area wounds were recorded, however, the section to record the waterlow risk score was blank.

We asked the deputy manager what other audits were completed. They told us the home did not audit health and safety or infection control, however, they did audit care

Is the service well-led?

plans and medicines. We asked to see care plan audits and were told by the regional supporting manager these had not been completed. However, we did see one care plan audit had been completed. We saw in the monthly visit reports dated 08 December 2014, 15 January 2015, 18 February 2015 and 24 March 2015 an action had been added to ensure care plan audits were completed. The records recorded 'The home manager and deputy have not completed care plan audits as required'. We saw these actions were rolled over in each report and no action was taken to ensure these were completed. Other actions recorded on the provider visit reports regarding the completion of meetings, appraisals and supervisions and improving training compliance were also not addressed and targets had not been met that were set in these reports.

We were told by the deputy manager the home did not complete an infection control audit. We looked at deep cleaning records for March and April 2015. We found records had not been completed on 25 days across these two months. Staff told us deep cleaning should be done in bedroom areas daily. We asked for housekeeping daily records. We saw records were from 2013 and 2014. We could not be sure infection risk was being managed appropriately at the home. We asked the deputy manager if the laundry was audited for infection control, they said it was not. We did see evidence the service contracted with a clinical waste supplier.

We asked to look at medication audits completed since February 2015. We looked at the daily medicine audits. In February 2015, 11 days had not been completed. The home was unable to locate any further daily audits. The deputy manager showed us the 'individual medication audit' to be used as part of the monthly quality returns. We could not find any of these records had been completed.

We looked at staff and resident satisfaction surveys. Resident survey results available at the home were from August 2012. The regional manager confirmed that surveys had been completed at the end of 2014. We were shown results from the provider group that the home belonged to; however, no results were available to show the specific feedback for Cookridge Court. We saw in the relatives meeting on 08 May 2014 a relative had commented, "It would be useful to have a relative feedback form so we can share our opinions with staff." We could not see any feedback from previous relative's feedback forms.

We were shown a copy of the home's 'participation policy'. This stated relatives should have access to a 'manager's surgery' and to surveys. It also detailed staff voices will be heard through supervision and appraisal systems. The policy stated 'management will make available and publicise reports in the form of quality assessment reporting, that details progress and actions plans for the future'. We could not evidence the participation policy was being adhered to.

We saw notices advertising monthly residents and relatives' meetings for 2015; these were to be alternate between an afternoon and an evening meeting. One person told us, "I attend the meetings and staff listen to people and change things," Several people said they didn't know anything about the meetings. One person said, "I've given up going to meetings now. I was a representative, but I felt like I was a spare part. They knew what they were going to do, so there's no point. I went to two or three and gave up."

We saw a resident/relatives meeting was held on 07 January 2015 and 08 May 2015, a night staff meeting on 19 February 2015 and a general staff meeting on 18 January 2015. We were told by the deputy manager that meetings were held on a monthly basis; however, there was no evidence to show this was happening. We looked at the records from the meeting on 08 May 2015 and saw subjects such as management changes, staffing levels, activities and training were discussed with relatives.

The staff we spoke with told us no team meetings were held, one staff member thought the handover was sometimes used as a team meeting. We asked for but did not receive any minutes of management meetings, staff meetings or a statement of purpose.

We asked the deputy manager to check for accidents and incidents within a specified time period using the service reporting system. We found they were unable to do this and did not know where information was stored or how to access the information within the monitoring system.

Handover was carried out between shifts and information was recorded in a notebook. The quality of messages was variable in terms of clarity and pages had been removed.

Communications between staff as well as between staff, relatives and people who used the service seemed to be poor. Many people reported not being informed about what was happening to themselves or their relatives. People didn't feel like they knew where to turn for

Inadequate

Is the service well-led?

information or support. The regional supporting manager told us they had identified communication issues within the home approximately six weeks ago but only realised in the last couple of weeks what those issues were. They said this was an area that needed some work.

We found care plans were kept in an open cupboard on the floors. We saw one care plan was left out on a desk along with a number of other folders that contained confidential information. The lockable cupboards containing care plans were often also left open. This meant people did not have their personal records stored in a way to protect their privacy and confidentiality.

The registered person did not have effective systems in place to monitor the quality of service delivery. This was in breach of regulation 17 (Good Governance); Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The care plans we looked at did not contain appropriate and person specific mental capacity assessments, which would ensure the rights of people who lacked the mental capacity to make decisions were respected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care We found that all the care plans we looked at were not updated on a regular basis, some sections were not completed appropriately or was inaccurate. This meant that we could not be sure that people were receiving appropriate care and support to meet their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The applications for the Deprivation of Liberty Safeguards had not been carried out appropriately.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that care and treatment was not provided in a safe way for people using the service because there was no safe management of medicines. Individual risks had not always been assessed and identified.

The enforcement action we took:
We have served a warning notice and the provider was told they must become compliant with the Regulation by 10 August 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing We concluded the provider had not taken appropriate steps to ensure sufficient numbers of staff were deployed in order to meet people's needs.

The enforcement action we took:
We have served a warning notice and the provider was told they must become compliant with the Regulation by 10 August 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment We concluded the provider had not taken appropriate steps to ensure people were protected from abuse and improper treatment.

The enforcement action we took:
We have served a warning notice and the provider was told they must become compliant with the Regulation by 10 August 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

The registered person did not have effective systems in place to monitor the quality of service delivery and did not have effective systems in place to identify, receive, handle or respond appropriately to complaints.

The enforcement action we took:

We have served a warning notice and the provider was told they must become compliant with the Regulation by 10 August 2015.