Mariposa Care Limited

# Cedar Lodge

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

Cedar lodge 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.

Cedar Lodge is a purpose built care home in a residential area of Stockton-On-Tees. The service provides care and support for up to 54 people who live with dementia and have nursing or residential care needs. Bedrooms and communal areas are provided over two floors. Each person has access to an en-suite bedroom and there are gardens to the rear of the service. 46 staff were employed. At the time of the inspection, there were 32 people using the service.

When we inspected in 2015, we rated the service 'Requires Improvement' overall. We found that staff training was not up to date and action needed to ensure all of the relevant checks for the building and equipment were carried out. We also found that a fire exit had been blocked which would have caused a delay in leaving the building during an emergency.

When we inspected in January 2017 we rated the service 'Requires improvement.' We found improvements had been made to staff training and relevant checks of the building and equipment had been carried out. However, we identified that there were insufficient catering staff deployed to meet people's dietary needs. Palatable options were not available for people who required a soft or pureed diet and risk assessments for people at risk of malnutrition had not been completed correctly. Risks to people had not been managed consistently. We also found that the management of medicines needed improvement and there was a lack of meaningful activity for people. Care records were cumbersome, difficult to navigate and did not accurately reflect people's needs. At the last inspection in January 2017, we asked the provider to take action to make improvements in all of these areas.

A registered manager had been in post since 7 August 2017. 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.

Since the last inspection in January 2017, eight incidents of abuse had been substantiated for neglect and organisational abuse. This meant there was evidence that abuse had taken place. Three of these alerts had been raised by the registered manager and five from health and social care professionals. Although staff had completed safeguarding training, they did not always recognise the risks to people. Care records and risk assessments were not always updated when incidents took place. There was no evidence that lessons had been learned.

Action had been taken to ensure more palatable meal options were available for people who required a soft or pureed diet. However, menu choices for the people requiring adapted diets did not provide a nutritionally

balanced diet. Risk assessments for people at risk of malnutrition had still not been completed correctly.

Staff had not undertaken specific training in nutrition aimed at supporting people who were at risk of choking, dehydration or malnutrition with their dietary intake. Accurate records were not in place for people who displayed these risks and staff did not always follow the correct procedures to support people to ensure their nutritional and hydration intake was sufficient. From our observations and review of care records we determined that people with these risks were placed at an increased risk of harm.

Robust measures were not in place to appropriately assess people's needs, the risks to them and then manage those risks. This included people at risk of falls, malnutrition and dehydration. People were also put at further risk of harm because staff did not follow health and safety procedures. This included not storing equipment away safely and rooms required to be locked for safely had been left open.

There were insufficient staff on duty at the service, which meant that people could not always go out into the garden or out into the community. People on the first floor were prevented from going downstairs by themselves because there was a risk of them leaving the building. No measures were in place to support people to go downstairs into the garden or out with staff. There were insufficient staff on duty on the first floor to attend to people's personal care and this caused delays in people receiving assistance. When staff were providing assistance to people there were no visible staff.

Information in care plans was not always accurate. At times, the information contained within them was contradictory. Records had not always been fully completed with the information needed, signed or dated. There was a lack of meaningful activity in place for people.

People's prescribed medicines were managed safely. However, there were delays in administering medicines when agency staff were on duty because there was a lack of support to these staff. 'As and when required' medicine records required further information to make sure staff unfamiliar to people had all of the information they needed to determine when it was appropriate to give these medicines. Systems to manage people's topical creams needed to be improved. Records did not show if people received their topical creams as prescribed.

The service was clean and tidy. However, we found that staff did not always have access to the equipment they needed. We observed that staff did not always follow infection prevention and control procedures.

Health and safety certificates were up to date. However, there had been a delay in taking appropriate action when an electrical safety certificate had been rated as unsatisfactory. This issue had been addressed prior to inspection, however this delay put people and staff at increased risk of harm. Fire procedures had generally been carried out; however, records of some checks had not been kept up to date. Personal emergency evacuation plans were not accurate and staff did not know if one person with a sensory impairment would be able to hear the fire alarm. No actions had been taken to address this.

Confidential records stored in the manager's office could be easily accessed from outside of the building as they were place next to an open window.

Staff had not received regular supervision and appraisal. Staff undertaking their induction had not always received regular reviews. All staff had undertaken mandatory training; however, the practices in place at the service showed that staff were not following the training they had received.

People were involved with health and social care professionals. Referrals had not always been carried out in

a timely manner and care records had not always been updated to reflect the guidance or recommendations provided by them.

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 supported this practice. Staff worked in line with the Mental Capacity Act 2005. However, records for best interest decisions had not always been recorded.

Everyone using the service lived with dementia, yet the environment was not dementia friendly. Some areas of the service needed to be updated because plasterwork was damaged or walls were stained. Some equipment needed to be replaced or repaired. There was a lack of signage to help people to navigate their way around the service.

People told us they were happy with the care provided by staff. We observed positive interactions between people and staff when care was being provided. However, we found that staff did not always have time to spend with people. People told us that there were limited activities in place for them and we observed people sat in silence in communal areas for long periods of time.

People had access to some assistive technologies, such as wheelchairs and stand aids. However, they did not have access to records and information in large font or in picture format.

Complaints records were in place. People and relatives told us they knew how to raise a concern or complaint if they needed to. At the time of the inspection, no-one using the service was receiving end of life care.

Significant improvements had not been made since the last inspection. Many of the same concerns had been identified during this inspection. Quality assurance systems were in place; however, they had not been critical enough to ensure continued improvement at the service. Where actions had been identified, they had not always been addressed. Some areas for improvement had not been identified. Some changes had taken place, however further improvements were still needed.

We received mixed reviews from relatives and staff about the visibility of the management team. Staff worked together as a team and communicated with each other. Information was shared with people and staff during meetings with them.

Systems were not in place to make sure the Commission was made aware of incidents taking place at the service without delay.

The overall rating for this service is 'Inadequate' and the service is in 'special measures.'

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still 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 this service. This will lead to cancelling their registration or to varying

the terms of their registration within six months if they do not improve. This service will continue to 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 so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

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

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.

Risks to people were not safely managed. The practices in place put people at increased risk of harm.

There were insufficient staff on duty to meet people's needs. There was a lack of support for agency staff.

Health and safety procedures were not always followed or timely action taken to make improvements.

People received their prescribed medicines when they needed them. Records did not show if people received their topical creams as prescribed.

### Is the service effective?

**Inadequate**

The service was not effective.

Staff had not received regular supervision and appraisal.

People at risk of choking, malnutrition and dehydration did not receive the right support. Records for these people were inaccurate. Staff had not received specific training in how to manage the risks to these people.

People without capacity were not always given a choice at mealtimes. Nutritionally balanced meals were very limited for people who required a pureed or soft diet.

The environment was not suitable for people who lived with dementia or had a sensory impairment. Some aspects of the service required repair or updating.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

Limited assistive technologies were in place for people. People did not have access to records in large font or pictorial format.

People told us they were happy with the care and support which they received from staff. We observed positive interactions between people and staff. People's privacy and dignity was not always maintained and respected.

Staff did not have time to spend with people outside of personal care, such as to sit and chat or have a cup of tea.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Care records did not provide information which was individual to each person. Records had not always been fully completed.

There was a lack of meaningful activity for people. People did not have the opportunity to go outside when they wanted to.

A complaints procedure was in place. People and their relatives told us they knew how to make a complaint.

## Is the service well-led?

**Requires Improvement**

The service was not always well-led.

The service had not made the improvements expected since the last inspection. People did not receive safe care and remained at risk of harm.

Quality assurance procedures were in place, however they needed to be completed more critically to ensure continued improvements took place.

Systems were not in place to make sure the Commission was made aware of incidents taking place at the service without delay.

# Cedar Lodge

**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 checked 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.

The Commission is aware of an incident which occurred in 2016 where a person died. This incident is subject to an investigation by the police and coroner. We did not examine the circumstances of this incident during this inspection. However, we did examine those at risk with nutritional needs.

Prior to the inspection, we wrote to the provider because they had failed to submit notifications without delay. We are taking action to deal with this matter outside of inspection and will provide an update when this matter is concluded.

We carried out an unannounced inspection on 8 May 2018 and 14 May 2018. Two adult social care inspectors, one specialist advisor and one expert by experience attended for inspection on 8 May 2018. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service Two adult social care inspectors attended for a second day of inspection on 14 May 2018. This inspection included observations of practice, discussions with people, relatives and staff and review of records.

Before our inspection we reviewed all the information we held about the service. We examined the notifications received by the CQC. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescales. We also contacted Stockton Council Commissioning team, Health Watch, South Tees Clinical Commissioning Group (CCG) and Stockton NHS infection prevention and control team. We used the information shared with us as part of our inspection planning.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 11 people and three relatives. We spoke with the registered manager, rapid response manager, one nurse, one clinical lead, a senior carer and six care staff. We also spoke with a cook, a member of laundry staff, a domestic member of staff and a maintenance member of staff. We spoke with a community matron who visited the service during inspection.

We reviewed nine care records in detail. We reviewed four recruitment and induction records and ten supervision and appraisal records. We reviewed the training summary records for all staff. We also reviewed records relating to the day to day running of the service.

We carried out a short observational framework for inspection (SOFI). This method of observation is used to capture people's experiences who are not able to voice them.

Inadequate

# Is the service safe?

## Our findings

When we carried out an inspection in January 2017 we found that risks to people had not been managed consistently and the management of medicines needed to be improved. We also found there were not enough catering staff on duty to meet people's dietary needs.

At this inspection we found that there were enough catering staff on duty and improvements had been made to the management of medicines. However, we found that people continued to be at risk of harm.

Risks to people had not been adequately assessed, monitored or evaluated. Where risk assessments were in place, they did not clearly and concisely indicate the actions which staff needed to take to reduce those risks to people. Information in risk assessments was not always accurate or up to date and risk assessments had not been regularly reviewed.
Care plans and recommendations sent from the falls team could not always be found in people's care records. This included recommendations for increased checks or using falls sensor equipment. This meant we could not be sure if staff were following the recommendations from health professionals.

A member of the falls team had recommended that one person needed falls detector equipment to reduce the risk of falls to them. The equipment was not in place during the inspection. Staff told us that they were broken, but could not tell us when this occurred or if the equipment was going to be replaced. The registered manager told us they would take action to address this. Records available showed staff last responded to the falls alarm on 26 February 2018 for this person. Staff had not assessed the risks again to this person after the equipment had broken to determine how to manage the risk of falls to this person. No further contact had been made with the falls team to request a review.

People at risk of falls were required to have regular health and safety checks carried out. These were checks of people take make sure they were safe. No records were in place on the first day of inspection to show these checks were being carried out as a measure to reduce the risk of harm to people. Action had been taken on the second day of inspection to implement these checks, however records in place showed that checks of people had not been carried out consistently. The times of checks had been pre-populated and did not represent the time the actual check had been carried out.

A falls sensor alarm to alert staff was located in the staff office during inspection. Staff could not say if the equipment had been charged during the night. The registered manager told us they had been a few issues with this equipment and had been trying to take action to resolve this. Whilst the alarm to alert staff was charging in the office, we observed that staff could not always hear the alarm sound because they were not working within the vicinity of the office. This meant people were placed at increased risk of falls.

Everyone using the service lived with dementia. People with nursing needs lived on the ground floor and people with residential care needs lived on the first floor. People on the first floor were not able to freely go onto the ground floor without assistance because staff felt they were at risk of leaving the premises, despite a locked door in use. Staff felt people would be at risk of accidental injury if they left the premises by

themselves.

We saw a notice on display to inform visitors of this and that they needed to take action to prevent people from entering the lift to go downstairs. One person told us, "All the doors are locked and you can't get out or go downstairs." Another person told us, "I don't like it here, I have to be accompanied in the lift to go downstairs. I have been in the garden once since I have been here." We determined that this was not a proactive measure to take to manage the risks to these people. Staff had not considered that letting people freely access all areas of the service or accompanying people on trips out locally could help to manage their behaviour.

During the inspection, we observed that staff practices routinely increased people to further risks of harm. For example, we observed one person sitting alone in the dining room on a table adjacent to a hot lock oven which was on and contained breakfast. They were unsupervised which increased the risk of harm to them through burns and scalds. Doors around the building that were required to be locked for safety, such as the cupboard which contained domestic cleaning products, were found to be unlocked during inspection. This also included electrical cupboards, rooms used for storage and a bathroom which contained five hoists.

Recommendations on the management of behaviours which challenge for one person, which had been shared as part of a preadmission assessment to the service, had not been incorporated into the person's care records. The recommendations included the use of music as a calming measure and giving the person a shower bottle to hold and smell to inform them that they would be supported to bathe. We spoke to two staff responsible for providing care to this person on the day of inspection and neither were aware of these recommendations. One staff member told us that they did not know if the person would be able to hear the music because of their auditory impairment, however no action had been taken to address this.

On both days of inspection, we observed the button on the lift was missing exposing a printed circuit board. This is a board which supported wiring components in electronic items. When we raised this, a staff member told that it didn't matter that the button was missing because we didn't need to touch it. Instead we could use the keypad on the lift to open the door. This was not safe practice. After inspection, the provider told us this button had been reattached.

When we visited one person in their room, we found a hoover and a stand aid had been left unattended. This increased the risk of harm to the person caused by slips, trips or falls.

An up to date chair scales calibration certificate was not in place, the registered manager took immediate action to address this during the inspection. An electrical installation check had been carried out on 10 and 13 October 2017. The electrical installation report stated the overall assessment of the installation was unsatisfactory. A number of actions were identified on the report. Some of these actions were recorded as C2 which meant 'potentially dangerous' and urgent remedial action was required because there was a risk of harm. Some actions were rated FI which meant 'further investigation was required without delay.'

The provider experienced a delay in receiving the electrical inspection report. The report was received on 16 November 2017 and an order for work to be carried out was placed on 28 November 2017. Remedial work started on 4 December 2017 to repair C2 ad FI actions. This meant immediate action had not been taken to undertake repairs to improvements where there was a risk of harm.

Personal emergency evacuation plans (PEEPs) were in place for people, however they did not always contain accurate information. For example, one PEEP stated that a person was mobile and could leave the building without support from staff. However, the person's care records stated they were at high risk of falls

and needed assistance from staff to reduce the risk of falls. The PEEPs showed that they were required to be reviewed every six months; the plans were last reviewed 19 July 2017.

Staff could not tell us if one person with an auditory impairment would be able to hear the fire alarm. No action had been taken to determine whether this person would respond to the alarm and no measures had been put in place as a result.

We observed staff dispensing eye drops and picking up sandwiches and putting them onto plates for people to eat without wearing gloves or washing their hands before and after. Hand gel containers on display in communal areas were empty. The walls underneath these dispensers were also stained. This meant the service was not following the correct procedures for infection prevention and control.

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

There were insufficient staff on duty on the first floor of the service. One senior carer and one carer were on duty throughout the day to provide care and support for 13 people. We saw that one person who needed support from two staff had wanted to get out of bed and dressed. The carer on duty told us the person had been waiting 40 minutes. The staff member told us they had not able to meet this person's needs because the senior carer was busy. There were no available staff on the ground floor to come and assist the staff member to support this person. From our observations, we determined that if the two staff working on this unit had been able to support this person, then there would have been no other staff available to provide assistance to anyone else on the first floor. Staff on duty told us this was a regular occurrence during busy times of the day. During our observations of staffing on the first floor, we found staff were not visible and people were left waiting for staff. The rapid response manager told us that staffing levels matched dependency levels. We questioned this because some people on the first floor required the assistance of two staff and the dependency tool did not consider the size and layout of the building.

There were insufficient staff across the service to allow people to spend time in the areas they chose. For example, people upstairs could not freely go downstairs because there was a code to use the lift. There was a notice on the lift to tell visitors not to take people downstairs. We determined if a member of staff from the first floor took a person downstairs, then only one member of staff would be left on the first floor. Whilst we were on the first floor, we observed two people asking to go downstairs. Staff told them they were unable to because they were busy.

People were not able to access the garden areas regularly. We heard people on the first floor asking to go into the garden, however staff were not visible and their requests went unheard. We did not see these people in the garden area during inspection. Staff told us people did go into the community, but this was not often because there were not enough staff to facilitate this. One staff member told us, "There are not enough staff to take people out. If two staff take two residents out, this leaves us short staffed."

We observed that an agency nurse was not supported to carry out their role. They had been orientated to the ground floor but not to people. No assistance was provided to the agency nurse to dispense medicines to people. As a result, the medicines round took longer than needed. No harm occurred to people as a result of the delay in giving medicines.

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

People had access to their prescribed medicines. These medicines were sufficiently stocked and medicine administration records had been completed.

Topical cream records did not contain accurate information and had not been completed correctly. One person's records referred to two creams. The records did not distinguish between which cream had been applied. The records stated to 'apply as directed.' Staff we spoke with were unclear about what this meant. The nurse and deputy manager told us this meant the person needed it as required, yet a carer told us the person received it every day during personal care. No action had been taken to contact the person's GP to seek clarification. This meant we could not be sure if people we receiving their topical creams as directed.

'As and when required' medicine records needed further information to show staff when people needed their medicines. For example, where people were in pain and could not voice this, the care records lacked detailed information to help staff recognise people were in pain and needed their medicines.

Fire safety checks were in place and had largely been carried out. However, we found that a fire safety record book had not been reviewed by the registered manager in March, April and May 2018 as required. A three-monthly review of essential fire checks had not been completed since 12 September 2017 and daily fire warden checks were last completed on 9 May 2018 and weekly fire warden checks last completed 23 April 2018. Planned fire drills had been carried out. A record dated 14 September 2017 stated that the competent person and two night staff involved in the fire drill did not know the door code of the emergency exit to allow people and staff to access the stairs in an emergency. The record did not show what action was taken to address this.

Since the last inspection, we received copies of all safeguarding alerts and minutes from the local authority. These records showed that eight safeguarding alerts had been upheld for neglect and organisational abuse. Three of these alerts had been raised by the registered manager and five alerts raised by health and social care professionals. Staff told us they would speak with the registered manager if they had any concerns about abuse. Staff had undertaken training in safeguarding, however we found they did not recognise how failing to manage the risks to people placed people at increased risk of abuse through neglect or organisation abuse. We could see that safeguarding had been discussed in meetings and supervision.

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

People told us they were happy with the cleanliness of the service and complimented staff about the standards which they kept. One person told us, "My room and bathroom are always clean and tidy." Another person told us, "The cleaners are in my room every day, cleaning and sweeping it. It's like a hotel. It is kept very clean." A relative told us, "[Person using the service's] room is lovely and clean."

Inadequate

# Is the service effective?

## Our findings

At the last inspection, we found that risk assessments for people at risk of malnutrition had not been completed correctly. Palatable options were not available for people who required a soft or pureed diet.

Since the last inspection, the provider had taken action to improve the variety of foods offered. Individual items of food were now blended and presented separately. However, further improvements were needed in this area.

We found that although changes had been made to the menu, little consideration had been given to ensuring people who received adapted diets obtained a nutritionally balance diet. For instance, over lunch people received mashed potato and spaghetti in tomato sauce, or at times were given pureed macaroni cheese or lasagne. Very few vegetables were available and when we discussed this with the kitchen staff they told us that it was difficult to provide people who needed adapted diets with vegetables as they could not use tomatoes or peas. We found no consideration had been given to the use of other vegetables or that not offering five portions of fruit and vegetables a day would be problematic. We found that although some fruit was provided, none was converted into items people on an adapted diet could eat. We found that staff did not recognise that even when at an appropriate weight people could become malnourished and lose weight if they did not have a balanced diet.

At this inspection we found that further improvements were still needed to manage the risks to people from malnutrition, dehydration and choking.

Nutritional risk assessments had been completed incorrectly. Staff incorrectly calculated people's body mass index (BMI) allowing people a more generous score. These scores did not accurately reflect people's weight. Two heights were recorded in people's care records. One in letters from dieticians and one on MUST risk assessments. The care records did not indicate which was the correct height. Staff had completed the MUST risk assessment based on the height in the care records. This meant it was not clear if the MUST risk assessments were correct. After inspection, the provider contacted us to tell us they had identified inconsistency in the care records, however the heights recorded in the MUST risk assessments were correct.

We saw one person had been involved with a dietician. The dietician sent a letter to discharge them which included key recommendations and a care plan. The person's care records had not been updated to reflect the information from the dietician. Generally, care plans for weight loss had not been regularly reviewed. For example, for one person, their care plan had not been updated since 12 January 2018 and the person had continued to lose weight.

People at risk of malnutrition were not weighed as regularly as they needed to be. This meant staff did not have a consistent overview of the risks to people to determine the action that needed to be taken to reduce the risk. Some people who needed to be weighed weekly to monitor their weight loss had been weighed monthly. For example, one person was placed on weekly weights because they had lost 3.6 kilograms since their admission. The person had not been weighed since 25 April 2018 where they weighed 52.8 kilograms.

This showed a 6.2 kilogram weight loss since the previous weight check 21 days prior.

No action had been taken by staff to refer this person to a dietician or to seek professional advice in relation to this person's health and well-being. A staff member told us they were unsure if this weight was correct yet no action had been taken to address this. Staff had not considered whether they needed to carry out a mid-upper arm circumference instead. This is another way of measuring a person's weight loss.

We reviewed an incident record for one person who was at risk of choking and required a pureed diet. We saw that this person had attempted to take a biscuit from another person's plate. Staff intervened and took appropriate action. However, the information about this incident was not updated in the care records and an updated risk assessment was not carried out. During our lunchtime observations, we saw that this person was not observed at that mealtime. This showed that staff had not recognized this incident as a potential risk. The incident record stated that a risk assessment had not been updated. The record stated, 'Unable to complete one as no risk management plan paperwork available.

During our inspection we observed a person unsupervised in their room with a jam sandwich and custard cream biscuit. A risk assessment for choking for this person stated that they should not be left to eat unattended. This risk assessment had not been regularly reviewed. Care plan reviews stated that the risk remained and staff continued to supervise the person. One staff member we spoke with told us this person did not require assistance with eating. Staff had not taken appropriate action to monitor and reduce the risk of choking for this person.

Timely referrals for assistance were not carried out, especially in relation to weight loss. Where referrals had been carried out, staff did not always ensure the recommendations from the health professionals were put in place.

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

One person had a percutaneous endoscopic gastrostomy (PEG) feeding tube in place. This is a means of introducing food and fluid through a person's stomach. The care records showed that the person had difficulties swallowing food following a stroke and therefore was at risk of choking. The care records showed that this person could eat a pureed diet as well as receiving food and hydration via their PEG. A speech and language therapy referral record stated that the person could have ten teaspoons of pureed food. Yet a nutrition and hydration care plan stated there were no restrictions with the amount of pureed diet they could have. The registered manager and staff could not tell us which was correct. During our observation of lunch, we observed that the meal provided had not been measured. We could see that the amount of food was greater than ten teaspoons. After inspection, the provider told us that the person was not restricted in the amount of food which they could eat.

A food preferences record stated that two scoops of thickener were required for all liquids to prevent choking. There was no information in the care records to show the size of the scoop or how much thickening powder to liquid was needed. Also, staff did not monitor how much fluid this person received even though their PEG prescription stated that they must have 50millilitres of fluid pre and post medication and another 900millilitres of fluid during the course of the day. This meant staff were not adequately managing the risks to people who had a PEG in place to manage their nutrition and hydration.

On the day of inspection and the two days prior to inspection, temperatures were reported to be 22 to 24 degrees Celsius. On our arrival to the service, we found the environment to be very hot. Windows were open

and some fans were in use. No drinks were available in people's rooms or communal areas. We saw the drinks trolley on display once. Staff had not taken the initiative to ensure people had readily available access to drinks.

We reviewed fluid balance records for people at risk of dehydration and found that people's fluid intake was lower than expected. Fluid balance records did not contain a target amount of fluid which people needed to consume. A continence assessment for one person stated that the person needed to consume 1600 millilitres of fluid each day. This information had not been recorded on the fluid balance record. We checked these records between 1 May and 7 May 2018 and the person had not achieved this amount on any of these days.

We found that staff did not tally the total amount of fluids people had taken each day and this information was not monitored or analysed to identify any patterns or trends. Staff were not acknowledging the risks to people on food and fluid balance records. These records were not routinely checked and analysed to make sure people had received sufficient food and fluid intake each day and action put in place when this was not the case.

We reviewed menus which were shared with us after the first day of inspection; we found that many of the planned meal choices were not suitable for people who required a soft or pureed diet. For example, choices included pasta bake, sausage roll, sandwiches, and roast pork. There were days where both menu choices on offer at the mealtime were not suitable for people who required a specialist diet. For example, for lunch on the day prior to the inspection, the choice was pasta bake and sausage roll. On another day the choice had been macaroni cheese or a sandwich. None of these foods were suitable to be pureed.

There were days were only one choice was available. This was usually a Sunday lunch when one roast meat and vegetables were on offer. People did not have an alternative choice available. People told us the menu was repetitive. One person told us, "It's the same old stuff, all of the time. I'm bored of it." A second person told us, "The food is OK, but it is a bit repetitious." A third person told us, "The food is rubbish."

One person told us they liked to have their breakfast really early in the morning. They told us a member of night staff always made sure they had their breakfast at 07:00. When this staff member was not on duty, they usually had to wait until later to have their breakfast, which could be between 08:30 and 10:00. This person told us they did not like this.

We observed one person who needed assistance with their lunch have their meal put in front of them, which sat untouched for five minutes before the staff member came back to assist the person.

There were no written or pictorial menus on display at the service. Tables were not set for mealtimes, for example tablecloths, placements, condiments and cutlery. Drinks were only offered to people after their meal. Audits showed that tables were not set because of 'safety issues.' Staff had not identified what these safety issues were and had not identified suitable solutions to manage the risk to people.

This was a breach of regulation 14 (Meeting nutrition and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had not received regular supervision and appraisal. We looked at ten staff supervision and appraisal records. Some staff had not received any supervision, other staff had participated in two to five sessions. The provider's policy stated that staff must participate in supervision every six weeks with a minimum of six sessions each year. None of the ten staff had received an appraisal.

We reviewed four staff records who had started working at the service in the last six months to review their induction. The provider's policy stated that staff will participate in a review after four, eight and 12 weeks of employment to review their progress. There were no records available to show if one member of staff had participated in their induction reviews at the designated intervals or if their probationary period was successful. The other three staff had received their four-week reviews later than expected.

Training records were not fully up to date to show all of the training which staff had undertaken. We identified that staff had undertaken mandatory training which covered areas such as equality and diversity, health and safety, the Mental Capacity Act 2008 and fire safety. The registered manager told us that following concerns raised at the last inspection in 2017, staff had undertaken training to support people who required a modified dietary and fluid intake. This training covered safety aspects of providing support to people. The training did not cover how to support people with dementia and health-related conditions which affect people's nutrition and hydration to receive a nutritious diet. Following inspection, the registered manager told us they had sourced training for staff which could cover this area and was awaiting approval for this from the provider. Not all staff had undertaken training in dementia, however the registered manager had sourced an e-learning course for staff to undertake in the interim whilst further training was sourced.

Nurses had received informal training from a PEG nurse about caring for people with a PEG in situ. They had also received training in catheterisation and venepuncture. Planned dates were in place for verification of death and syringe driver training.

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

Everyone using the service lived with dementia, however the environment at the service was not dementia friendly and did not reflect best practice in dementia care. The Department of Health, Health Building Note 08-02 Dementia-friendly Health and Social Care Environments (March 2015) states, 'The use of colour and the layout of the buildings, can make an enormous improvement in people's quality of life, and can reduce the impact of their dementia and help them live more independent lives. The correct colours, texture and layout of the buildings can help to reduce confusion, isolation, and anxiety, and help people live well with their dementia.'

There was limited signage in use at the service. It was unclear whether bedrooms were in use because doors did not have a name or photograph. One bathroom did have signage on it, however an arrow which should have pointed to this room pointed in another direction. There was no signage in place to navigate people to different areas of the service.

Some aspects of the service required repair or updating. For example, damage had been caused to some walls where items had been removed leaving holes in the walls. Staff did not have access to a working vacuum cleaner on the first day of inspection. Immediate action was taken to address this. On the second day of inspection, staff did not have access to a carpet cleaner and were observed mopping stained carpets in an attempt to clean them.

Infection prevention and control procedures at the service needed to be improved. In one bathroom, we saw that the seal between the floor and the walls had lifted. In another bathroom, the toilet roll holder was missing; we saw that the toilet roll had been placed on the bin for people to use. One person did not have a toilet seat in their en-suite toilet. Areas of the laundry room were worn, particularly areas of the floor and window sills. Walls were stained from mops and hand washing stations. One dryer and one washing

machine were awaiting repair. The ironing board cover was worn and staff were using a sheet to cover the damage.

This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Contrasting colours were not used on light switches and internal doors, for example to distinguish between a bathroom and bedroom door. Dementia friendly toilet seats are usually blue. None were in use at the service. Blue hand rails were in use in corridors and stood out from the cream walls.

Pictorial menus were not in place for people living with a dementia and for people who had a visual impairment. Staff had not recognised that these were needed. There were no visual prompts to navigate people to the dining room. Dementia friendly crockery was not in use. Red coloured plates can make foods such as mashed potato stand out and mean it is much more likely to be eaten.

An activity table for people with dementia, which contained a variety of locks was located at the bottom of the corridor was not accessed by people because it was not visible.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff understood the action they needed to take if they suspected people may not have capacity to make their own decisions. DOLs authorisations were found in people's care records. Care plans did not routinely show which aspects of their care people could consent to and areas where they may need assistance to make decisions.

The care records showed that one person received their medicines covertly. This meant staff hid medicine in foods such as yogurt. A letter was in the person's care records to show that the GP was happy for staff to do this, however there was no evidence of a best interests meeting or record to show that the people involved in this decision consented to this arrangement.

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

Requires Improvement

# Is the service caring?

## Our findings

People told us their privacy and dignity was respected and maintained during personal care. Outside of personal care, we saw practices in place which compromised people's privacy and dignity. During inspection we did see one person getting dressed because their door had been left often. We saw that people wearing protective aprons at mealtimes did not always have these removed after eating. We spoke with a staff member about people who needed assistance with eating and they referred to people who need assistance as 'feeders.'

We saw stained items of clothing in the laundry which were in the process of being ironed. From speaking with staff we identified that people regularly wore these stained items of clothing. No action had been taken to purchase new clothes for people to replace the stained clothing.

We visited one person in their bedroom and found their room to be very sparse. The mattress contained a stained fitted sheet. The person did not have any additional sheets or a duvet. Staff on duty could not tell us if these had been removed for cleaning and had not taken action to ensure the person had the bedding they needed. Staff had not considered speaking to the person to discuss whether they wanted any further furniture, personal or decorative items for their bedroom.

People had access to a small range of assistive technologies. These are products and services that empower disabled people to become more independent. Under the Equality Act 2010, assistive technology is recognised as a 'reasonable adjustment' which should be made available to prevent discrimination in a wide variety of contexts.

People who needed wheelchairs, walking frames and pressure reliving mattresses had them in place. Some people had their own mobile phones to keep in contact with people and had access to Wi-Fi. Staff told us people did not access the Wi-Fi and were not sure if people new how to use this. There were no computers for people to access.

Assistive technologies were not in place for sensory impairments. For example, personal listeners (small personal amplifiers) and flashing fire alarms, sensors or buzzers were not in place for people with hearing impairments. Video magnifiers were not in place for people with visual impairments. Care records, menus, newsletters and residents meeting minutes in large font had not been made available to people who were visually impaired.

People were not able to be as independent as they wanted to be. We saw that people on the first floor could not come onto the ground floor or go into the garden because they needed a staff member to take them down stairs. This would have left one member of staff upstairs. We also saw that people at risk of falls could not go into the garden independently.

Care records were in place for one person who displayed difficulties communicating. The person ha an auditory and visual impairment. Staff had not considered or trialled different methods of communicating

with this person. Care records showed another person had macular degeneration, which affects vision. Information in large font and picture format was not available for these people. Records did not show how these people were involved in making decisions such as personal care, dietary choices and activities.

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

People told us they were supported by staff and spoke positively about the care and support which they received from staff. One person told us, "The staff are very good here. They look after me well. If I need anything, I just have to ask." Another person told us, "The nurses are very kind and caring." A third person told us, "Carers are very good. They do a good job." A relative told us, "The staff are lovely. Very, very compassionate and caring. [Person using the service] gets well looked after." Another relative told us, "Staff are very sunny and kind, always smiling."

We observed positive interactions between people and staff. We saw that people were response to the care and compassion shown by staff. Staff spoke directly to people at eye contact level and spoke discretely to offer assistance to people who needed this. We saw that staff used appropriate touch to offer reassurance to people.

Relatives told us staff offered gentle encouragement to keep people mobile. Such as encouraging people to use their equipment to walk around the service. One relative told us, "[Person using the service] walks everywhere with their zimmer frame." Another relative told us, "Staff are always encouraging [person using the service] to walk. When they are tired [person using the service] uses a wheelchair."

Staff told us they enjoyed working at the service. One staff member told us, "I love my job. I enjoy interacting with the residents." Another staff member told us, "I love coming into work and being with the residents." A third staff member told us, "I enjoy working at Cedar Lodge. The residents are well looked after and cared for."

We saw that staff had limited time to spend with people outside personal care. Staff did not have time to sit and chat with people. Staff told us they did not have time to spend participating in activities with people. People told us their relatives and friends could visits them at any time and staff had made them feel welcome on their arrival.

There were inconsistencies in people's records to show whether they had been involved in planning and reviewing their care. Care plans, for example, had not always been signed by people or relatives with lasting power of attorney. We did see staff asking for people's permission before care and support took place and we did observe some people being offered choices, such as what to wear and whether they would like a bath.

Requires Improvement

# Is the service responsive?

## Our findings

At the last inspection we found that there was a lack of meaningful activity for people. Care records were cumbersome, difficult to navigate and did not accurately reflect people's needs.

At this inspection we found that the provision of activities still needed to be improved. We found care records were easier to navigate, however improvements were still needed.

Care plans did not contain information which addressed people's individual needs. For example, in a care plan for physical well-being, the identified need was for the person not being able to use the call bell. The care plan did not show how staff would manage this identified need, such as increased checks of the person. Instead the care plan contained information about weight loss. This meant care plans did not meet the needs of people.

Care plans lacked the relevant information needed to provide the right care and support to people. For example, a care plan for covert medicines stated that staff needed to put the medicine in 'suitable foods' but did not state what these suitable foods were. A catheter care plan for one person did not detail the size and type of catheter which the person needed.

Pre-written care plans were in place, where people's names had been inserted into the gaps within the text. This meant people had identical care plans in place for areas such as 'inability to use call bells' and 'Deprivation of liberty safeguards.' These care plans were not person-centred and therefore individual to people and their needs.

This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some care records had not been fully completed. For example, records which go with people into hospital to provide hospital staff with information about people contained gaps where information was missing. Information in care plans had been crossed out, but not signed or dated. This meant it was unclear about when the changes were made. Not all care plans and risk assessments had been signed or dated by the staff member completing them.

A care plan for one person had been hand written onto an A4 piece of paper instead of a care plan record. A similar area of improvement was highlighted in a review by the clinical commissioning group (CCG) following their visit in December 2017.

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

Throughout inspection, we observed communal areas to look at the activities available to people. We saw one activities session taking place with three people on the first day of inspection with an activities member

of staff. On the second day of inspection, we saw two care staff attempt to facilitate a gardening session with three people. We found this session was compromised because one member of care staff was called away and the other member of care staff was trying to facilitate the session whilst observing another person walking around the garden. Whilst the two care staff were carrying out this gardening session, we saw it left the remaining care staff stretched.

People and staff told us the provision of meaningful activities needed to be improved. One staff member told us, "There could be more activities." One person told us, "There is nothing to do here. It is very boring. I have been outside once. I eat and sleep; that's all I do." Another person told us, "An odd carer comes in and chats about what I used to do when I was young. But that's about it." A third person told us, "I just sit about mostly in my room. I like to watch the television."

Throughout both days of inspection, our observations showed that people were left sitting in their bedrooms and communal areas without meaningful activity. For example, people were sat in communal areas without a radio, television, sensory activity blankets, rummage boxes, crafts, newspapers or books. People were not asked if they would like to participate in activities of daily living such as washing up, folding linen or dusting. After inspection, the provider told us people had been involved in plans to redesign the garden area to make it more accessible for people. No dates were provided about when these plans would be implemented.

The registered manager told us that activities did take place at the service and that activities staff were in place across the week to the equivalent of a full-time staff member. Records did not demonstrate that people were regularly involved in activities on a one-to-one or group basis.

This was a continued breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We raised concerns at the last inspection about the provision of activities for people. Robust action had not been taken to address this. From our observations, activities were not managed in a way to provide meaningful activities to people regularly which was in line with their needs, wishes and preferences. Specific activities were not routinely in place which met people's dementia and sensory impairment needs. Activities were not delivered in short bursts to accommodate people's attention spans and to reach the widest audience.

Sufficient funds were not in place to provide the resources needed for activities. Staff participated in fundraising activities and came into work on their days off to take people out into the community or to participate in fundraising events. No observations had been carried out to determine which activities people had engaged well with and whether there was a time of day where activities were well received. No analysis of activities overall had taken place to determine whether the service was meeting people's social needs and whether they received sufficient and appropriate stimulation.

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

A complaints policy and procedure was in place. People told us they would speak to a member of staff if they were unhappy. One person told us, "I would speak to staff if I had any complaints." A small number of complaints had been made and records were in place to show they had been dealt with.

Requires Improvement

# Is the service well-led?

## Our findings

When we carried out an inspection in 2015 we rated the service 'Requires improvement.' Staff training was incomplete and checks of the building and equipment had been not been carried out.

When we inspected in 2017 we found these issues had been addressed. We rated the service 'Requires improvement' for a second time. We found that there were insufficient catering staff deployed to meet people's dietary needs. Palatable options were not available for people who required a soft or pureed diet and risk assessments for people at risk of malnutrition had not been completed correctly. Risks to people had not been managed consistently. We also found that the management of medicines needed improvement and there was a lack of meaningful activity for people. Care records were cumbersome, difficult to navigate and did not accurately reflect people's needs.

At this inspection we found that improvements were needed across the service. Although some action had been taken to make improvements at the service, we found the risks to people had increased. As a result, we determined that the overall rating of the service to be 'Inadequate.'

Systems were in place to monitor the quality of the service. However, we identified the audits carried out did not highlight the level of concerns found during this inspection. The audits were not completed in a thorough manner and staff did not use them to critically assess the service and these gaps had failed to allow continual improvements to take place.

We saw that some areas identified in audits as needing improvements had not been actioned. For example, a care plan audit highlighted that the risks in a choking risk assessment had not been included into the relevant care plan in January 2018. At this inspection, we found action had not been taken to address this. The care plan audit did not highlight that the care plan stated that this person should have snacks available in their bedroom, yet they should always be supervised when eating because of the risk of choking. No observations had been carried out to determine whether staff carried out the actions identified within the care plan. These observations would have highlighted that this person was left unsupervised to eat.

Audits of the mealtime experience had taken place and staff had tasted the food on offer. The findings of these audits were positive and not in line with our concerns during inspection. We noted no feedback had been sought from people who required adapted diets.

A nutrition audit carried out in March 2018 scored highly and overall was positive. This audit did not reflect our findings. We determined that it was not carried out critically enough. We questioned whether some of the information used in the audit was correct because we determined that BMI and MUST calculations were incorrect. The scope of the audit needed to be expanded to review people at risk of malnutrition, on weekly weights and to sample food and fluid balance records. This would determine whether calculations were correct and to determine whether people needing to be weighed weekly were being weighed weekly.

Despite the concerns identified with nutrition at the last inspection, no action had been taken to source

appropriate training to manage the risks to people who were at risk of choking, dehydration and malnutrition.

Audits had not highlighted that the environment did not meet the needs of people living with dementia and a sensory impairment, that some areas of the service needed to be updated and infection prevention and control procedures needed to be improved. The provider audit and registered manager supervision records had highlighted that the frequency of supervision and appraisal needed to be actioned immediately, yet significant gaps in the frequency of these were identified during this inspection.

A care plan audit for one person's records related to a different person. Some audits did highlight gaps in the frequency of reviews of care plans and risk assessment but improvements to the frequency of reviews were not observed during inspection.

A provider audit completed in January 2018 highlighted observations had not been carried out for a person at risk of falls. At this inspection, we saw that no observation records were put in place until we highlighted this on the first day of inspection. This audit also highlighted that menus were not in place for people and that menus were needed for people who required a soft and pureed diet. These were not in place at inspection. This meant that although the provider had identified these issues as areas for improvement, action had not been taken to address this.

We heard mixed reviews about the management team. One relative told us, "I know who the [registered] manager is, but I don't see them around much." Another relative told us, "I don't know who the [registered] manager is." One person told us, "The [registered] manager comes upstairs now and again. I see her about." Staff told us they did not see much of the management team. We saw that the management team were not visible in clinical areas and barriers were in place which prevented staff from raising concerns.

This lack of oversight had led to people at risk of falls, malnutrition, dehydration and choking becoming at increased risk of harm. The management team's office was located at the entrance of the service and thus was away from clinical areas. This lack of oversight increased the risk of harm to people.

Staff spoke about the vision and values of the service. We observed that barriers were in place which prevented these from being implemented at all times, such as insufficient staff. We also found that people were placed at increased risk of harm and dignity was not always respected or maintained.

When we arrived in the carpark of the service on the first day of inspection, we found the window to the registered manager's office was wide open; we were able to access confidential documents which had been left on the window sill. This room contained a variety of confidential electronic and paper records which had been left unsecure. When we entered the building, we saw that this remained the case until the registered manager arrived.

Offices in the clinical areas of both floors were continually left open. This meant confidential information and records was not kept secure. Medicine administration records were frequently observed to be open and left in view on the unattended medicines trolleys.

Regular 'walk arounds' of the service with a critical eye would have identified visible risks, such as unlocked doors, unsecure records, broken equipment and areas which needed to be updated.

Services that provide health and social care to people are required to inform the CQC of deaths and other important events that happen in the service in the form of a 'notification. Systems were not in place for staff

to complete and submit notifications in the registered manager's absence. Staff did not have access to a computer and did not have access to paper records to be able to fax the notification.

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

Prior to inspection we wrote to the provider because notifications had not been submitted without delay. We are dealing with this matter outside of the inspection process and will report on this when the matter is complete.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We will take action outside of this inspection to address this. We will report on any actions once they have been completed.

Meetings were in place for people and their relatives. They were kept informed of events and changes taking place at the service. Where issues were raised, information was provided to people and their relatives to address these. Staff attended staff meetings and a range of areas were discussed, such as training, safeguarding and the mealtime experience.

Prior to the inspection, we contacted the local authority who did not raise any concerns about how the service worked with them. We saw records in place to show the service did have contact with health and social care professionals. Safeguarding records showed that the service did attend meetings, did carry out investigations and did supply the information requested.

A community matron told us they had good links with the service. They told us, "We don't receive inappropriate referrals from staff. Staff are always visible and approachable and appear caring."

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 |
| Treatment of disease, disorder or injury | Quality assurance measures were not robust enough to allow continual improvements to take place. Records were not stored securely. |

**The enforcement action we took:**

We issued an urgent notice of decision to prevent admissions to the service unless these had been agreed by CQC.