Unity Homes Limited

Cambridge Court Care Home

Inspection report

17-19 Cambridge Road
Waterloo
Liverpool
L22 1RR
Tel: 0151 928 2249

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This unannounced inspection of Cambridge Court took place on 7 September 2015.

Cambridge Court Care Home is located in Waterloo in Liverpool. It has 59 bedrooms some of which have en-suite facilities. The home has undergone a recent refurbishment. The home provides 24 hour long term care, respite residential care and care for residents with nursing and dementia care requirements.

A registered manager was not in post. A manager had been appointed and commenced in post and they had applied to Care Quality Commission (CQC) as the registered manager and this application was in process. A registered manager is a person who has registered with the CQC 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.

People living in the home and relatives we spoke with told us they felt the home was a safe place to live. One person told us, "I'm safe yes, staff treat me well."

Summary of findings

Not all staff had received safeguarding training to enable them to identify and respond appropriately to potential allegations of abuse. You can see what action we told the provider to take at the back of the full version of the report.

Medicines were not always stored securely though procedures were in place to ensure safe administration of medicines. People we spoke with told us medicines were managed well.

Staff recruitment checks were completed prior to employment, to ensure staff were suitable to work with vulnerable people. Staff did not have the required photographic identification held within their personnel files.

Our observations showed people were supported by sufficient numbers of staff who completed regular checks to ensure people's safety, comfort and wellbeing in accordance with individual need. People told us there were mostly sufficient numbers of staff available to support them.

We saw risk assessments in areas such as falls, nutrition, mobility, pressure relief and use of bed rails. However, risk assessments were not always in place to identify potential risks, such as not having access to a call bell. There was no guidance regarding what actions staff should take to minimise risks and protect people's safety and wellbeing.

Systems were in place to maintain the safety of the home. This included health and safety checks of the equipment and building.

Staff felt well supported and able to carry out their role effectively; however personnel files did not reflect this. Staff did not receive an annual appraisal and had not received a comprehensive induction to ensure they had the skills and knowledge to fulfil their responsibilities.

People at the home were supported by the staff and external health care professionals to maintain their health and wellbeing. People told us a doctor would be contacted if they were unwell.

We saw that procedures were not in place to ensure that people's liberty could not be restricted unlawfully in line with the Deprivation of Liberty Safeguards (DoLS). It had not been assessed as to whether an application for DoLS was necessary.

People's consent was not always sought regarding their care and treatment. Decisions made in line with the Mental Capacity Act (2005) were not always clearly recorded in people's care files. We made a recommendation in the main body of the report regarding this.

People's nutritional needs were assessed and monitored and referrals to appropriate healthcare professionals were made if necessary. People we spoke with gave positive feedback regarding meals and told us there was always a choice of meals available that met their nutritional needs and preferences.

The environment had not been adapted to promote independence for people living with dementia. We made a recommendation in the main body of the report regarding this.

We observed positive interactions between staff and people living at Cambridge Court. Staff were mainly warm, kind and caring when interacting with people and people told us staff looked after them well.

We observed that records containing people's personal information were not always stored securely. We made a recommendation in the main body of the report regarding this.

People's preferences regarding their care were not always met.

There were a number of relatives visiting on the day of inspection. People told us visitors were always welcomed in the home, encouraging people to maintain relationships.

People's care files had a personalised plan of care which contained detailed information regarding people's care needs. Care documents showed regular reviews had been completed, with any changes in people's needs being clearly recorded, to ensure staff had up to date information about the needs of everyone living at the home.

An activities co-ordinator was employed by the service and they regularly supported people to go out of the home in the mini bus, which people told us they enjoyed.

Summary of findings

The home had a policy and procedure for managing complaints which was available to people within their service user guides. People we spoke with told us they felt able to speak to staff and were confident they would be listened to.

We received positive feedback regarding the management of the home. People told us communication was good between staff and relatives.

We saw that there were a range of audits (checks) completed, including areas such as medicines, care plans, fire safety, infection control, nurse call bells, mattresses and health and safety to ensure the quality and safety of the service provided. However, they were not always effective and had not picked up on some of the concerns we identified during this inspection.

Arrangements were in place to seek the opinions of people and their relatives, so they could provide feedback about the home. These included resident's and relative's meeting's and quality assurance surveys.

We found some incidents had occurred which should have been reported to CQC as legally required but had not.

You can see what action we told the provider to take at the back of the full version of the report.

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?

Requires improvement 

The service was not always safe.

People who lived at Cambridge Court told us they felt safe and visitors agreed with this.

Not all staff had a good understanding of safeguarding processes and some staff had not received training to ensure they had the knowledge and skills required to meet the needs of people living in the home .

Recruitment checks had been completed to ensure staff were of suitable character to work with vulnerable people. Required photographic identification of employees was not held within their files.

Risks had not always been assessed to ensure actions had been taken to minimise these risks.

Sufficient number of staff were employed to offer support in accordance with people's individual need.

Medicines were not always stored securely.

Arrangements were in place for checking the environment to ensure it was safe.

Is the service effective?

Requires improvement 

The service was not always effective.

People at the home were supported by the staff and external health care professionals to maintain their health and wellbeing.

Staff told us they were well supported, however records did not reflect this as there were a lack of training, induction and annual appraisals completed.

Deprivation of Liberty Safeguards applications had not been considered for people as required in line with the Mental Capacity Act 2005, to ensure their liberty was not restricted unlawfully.

The environment had not been adapted to promote independence for people living with dementia.

Care files evidenced that people had been consulted about their care. When people were unable to make decisions there was evidence that relevant people had been involved in making best interest decisions, though this process was not always clearly recorded.

We received positive feedback regarding meals. People told us there was always choice. Records showed that people's nutritional risk had been assessed and relevant healthcare professionals consulted when necessary.

Summary of findings

Is the service caring?

Requires improvement 

Overall, we observed positive interactions between staff and people living in the home. People told us staff were kind and caring.

Relatives we spoke with told us they had been involved in care planning and we observed documented meetings between staff and relatives to discuss care plans.

People's confidentiality was not always maintained. We observed that records containing personal information were not always stored securely.

We observed people's dignity and privacy being respected by staff in a number of ways, such as staff knocking on people's door before entering. However, our observations showed this to be inconsistent.

Is the service responsive?

Requires improvement 

The service was not always responsive.

People we spoke with were happy with the support they received and the care files we viewed evidenced that people's care and treatment had been discussed with them or their relative.

Care plans were person centred and included information regarding people's preferences.

People told us they were not always able to choose their daily routines, such as when to get up in the morning. People did have choice regarding the gender of staff supporting them with personal care needs.

There was no planned programme regarding activities available within the home, though people told us they went out regularly on the mini bus.

A process was in place for managing complaints and those received had been investigated in accordance with the home's policy.

Arrangements were in place to seek the opinions of people and their relatives, so they could provide feedback about the home. This included satisfaction surveys and residents' meetings. Actions taken following feedback were not always recorded.

Is the service well-led?

Requires improvement 

The service was not always well led.

The home did not have a registered manager in post. The proposed manager had applied to the Care Quality Commission (CQC) for the position of registered manager; their application was being processed at the time of our inspection. We received positive feedback about the manager from staff, people who were living at the home and relatives.

The manager and provider completed various audits (checks) to ensure the quality and safety of the service provided, and drive forward improvements. However, they were not always effective.

Summary of findings

We found on inspection that some issues requiring the home to notify the CQC had not been made.

Arrangements were in place to seek the opinions of people and their relatives, so they could provide feedback about the home.

Cambridge Court Care Home

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 7 September 2015.

The inspection team included an adult social care inspector, an inspector manager, a specialist advisor and an expert by experience. A specialist advisor is a person who has experience and expertise in health and social care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home. This usually includes a review of the Provider Information Return (PIR). However, we had not requested the provider submit a PIR prior to this inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We looked at the notifications the Care Quality Commission (CQC) had received about the service. We contacted the commissioners of the service to obtain their views.

During the inspection we spoke with the manager, the provider, 10 staff members, eight people who lived at the home, eight visitors, including relatives and visiting healthcare professionals and the chef.

We looked at the care files for five people, four staff recruitment files, medicine administration charts and other records relevant to the quality monitoring of the service. We made general observations, looked around the home, including some people's bedrooms, bathrooms, the dining rooms and lounges.

Requires improvement

Is the service safe?

Our findings

People who lived at Cambridge Court told us they felt safe and visitors agreed with this. People's comments included, "I'm quite safe, staff treat me well" and "Safe on the whole, yes." A visitor told us they, "Feel people are safe here. I've no concerns."

We spoke with staff about adult safeguarding, what constitutes abuse and how to report concerns. Not all staff had a good understanding of safeguarding processes and some told us they had not received any safeguarding training. The training matrix (monitoring record) provided to us showed that 20 of the 42 staff had not received safeguarding training and no staff had received whistleblowing training. This means there was a risk people would not be protected from potential harm and abuse as not all staff could recognise the signs of abuse or know how to raise concerns. The manager told us further training was being arranged for staff.

Safeguarding policies and procedures were available and contact details for the Local Authority were available to staff. Safeguarding referrals had been made to the Local Authority as required.

Not having effective systems and processes in place to protect people from abuse was a breach of Regulation 13(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Five care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, nutrition, mobility, pressure relief and the use of bed rails. The tool being used to assess a person's skin integrity risk advised that if the level of risk was high then it should be reviewed weekly. The records showed this was being reviewed monthly. The manager told us the tool had been printed incorrectly and should read monthly and they said they would ensure it was amended. Where risks were identified, measures were put in place to reduce the risk of harm to people, such as the use of pressure relieving mattresses and bed rails.

We observed that not all people have access to a call bell when in their rooms. A person told us, "If I needed help I'd find someone or shout" and another person stated, "I have no call bell, just have to shout." We observed a person in their room banging on a table and calling out for staff. There was a call bell in the room but it had not been left within reach, meaning the person could not request support when needed. The manager told us the person was unable to use the call bell and often threw it on the floor so it was not left with the person. A care plan was in place that stated the person was able to use the call bell but that they often pressed the emergency buzzer inappropriately and threw the bell at staff when upset. There was no risk assessment in place to identify how not having a call bell would impact on the person and what measures were in place to minimise any risks. This meant that people may not be able to request support when they needed it.

Not ensuring appropriate care and treatment is planned to meet people's needs is a breach of Regulation 12(2)(a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the home was staffed. Most staff told us that there were enough staff on duty to ensure people received the support they needed. Most visitors and people living in the home agreed that there were enough staff to meet people's needs but that at times staff were very busy and may not respond as quickly. A person told us there were, "Enough staff yes, just about" and "Sufficient staff definitely." Our observations told us there were adequate numbers of staff on duty on the day of the inspection to meet people's needs. For instance, we observed staff taking time to sit and chat to people during the day and supporting people to the toilet when they requested.

We looked at the staffing rota and this showed the number of staff available. At the beginning of our inspection the night staff were on duty and they included one nurse, one senior carer and four carers to support 42 people living at the home. Later in the day the manager was on duty with two registered nurses, two senior carers and seven carers as well as kitchen and domestic staff. The staff ratio was consistently in place to provide necessary safe care.

A staffing analysis had been completed to establish the number of staff required to meet people's needs. This showed that there was sufficient staff to provide effective care to people. We were told the analysis was based on the assessed dependency level of each person living at the home. There was no recording of people's dependency level and the manager told us they had not been documented. The manager agreed to review how this was recorded.

Requires improvement

Is the service safe?

We looked at how staff were recruited. We saw four personnel files and evidence of applications forms, references and Disclosure and Barring Service (DBS) checks had been carried out prior to new members of staff working at the home. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff. Staff registered with a professional body had their registration checked. The personnel files did not contain the required photographic identification of prospective employees, though this would have been checked as part of the DBS process. The manager told us they would ensure all staff files contain photographic identification.

We looked at how medicines were managed in the home. People we spoke with told us medicines were administered by registered nurses. Staff competencies around the safe management of medicines were checked to ensure they had the knowledge and skills to administer medicines safely to people. People had reviews of their medicines by their GP to ensure their wellbeing. Regular audits were completed by the manager and staff completed more frequent checks, though records showed these were not always daily as was described by staff. A medicine policy was available and protocols were in place for people who required PRN (as required) medicines.

There were effective processes in place for ordering medicines. Most medicines were kept secure in a locked medicine trolley in a locked clinic room. Daily temperature monitoring of the clinic room and medicine fridge were recorded. The majority of medicines were administered from a blister pack (medicines dispensed in a sealed pack). Those medicines not in a blister pack were counted regularly to ensure accuracy. We checked a sample of medicines in stock against the medication administration records and found these to be correct. Creams applied by carers were kept in locked drawers in peoples bedrooms; the key to these drawers was hanging on a wall in an accessible area. This meant that medicines were not always stored securely. The manager was made aware of this and removed the key. The manager advised the key would be held by a staff member at all times to ensure the medicines were secure.

Arrangements in place for administering medicines covertly (hidden in food or drinks without the person's knowledge) were reviewed. Medicines are generally only administered in this way if the person actively refuses medicines that are required to maintain their health and wellbeing and they lack the capacity to understand the consequences of refusing them. Decisions to administer medicines covertly in a person's best interest should include relevant health professionals such as the person's doctor and pharmacist, and be made in line with the principles of The Mental Capacity Act 2005. This is legislation to protect and empower people who may not be able to make their own decisions. The records we viewed showed that relevant health professionals had been included in the decisions and detailed care plans were in place to advice staff how to administer the medicines safely.

We observed staff supporting people to maintain their safety, such as assisting people to mobilise using walking aids or wheelchairs. Some corridors within the home contained equipment such as hoists and wheelchairs throughout the day. These were trip hazards for people moving around the home. The manager was made aware of this and agreed to speak to staff to ensure corridors were kept clear to reduce the risk of potential accidents. The manager advised there was a designated room for equipment and would ensure staff use this.

Arrangements were in place for checking the environment to ensure it was safe. A fire risk assessment of the building was in place and people who lived at the home had a PEEP (personal emergency evacuation plan) to ensure their safe evacuation in the event of a fire. Safety checks of equipment and services had been undertaken, such as fire prevention, infection control, water temperatures, gas and electrical equipment and mattresses. There was a system in place to report any maintenance work required and this was ticked off when completed to ensure the home was kept in a good state of repair.

We observed a number of doors throughout the home to be held open by wedges. This meant that in the event of a fire these doors would not close and people would not be protected from the risks relating to fire. The manager was made aware that use of wedges does not comply with fire safety guidance and agreed to remove the wedges and look at safe ways of holding doors open. Since the inspection the manager has told us devices for holding open doors safely have been ordered.

People we spoke with did not have any concerns regarding the cleanliness of the home. Comments included, "It's

Requires improvement

Is the service safe?

clean, always is" and "Spotless, lovely rooms. Constantly cleaning, can't fault the cleanliness." We observed rooms to be clean, however, the flooring of one dining room was sticky underfoot and there were a number of chairs in one lounge which had visible dirt over the arms. The manager told us the chairs were due to be thrown out, but in the meantime were used with covers over the arms. The manager agreed to review cleaning procedures within this area. Staff had access to gloves, aprons and hand gel and were observed wearing them when providing care to people in line with infection control guidance.

Requires improvement

Is the service effective?

Our findings

People at the home were supported by the staff and external health care professionals to maintain their health and wellbeing. The care files we looked at showed people received advice, care and treatment from relevant health and social care professionals, such as the GP, social worker, dentist, chiropodist, dietician and through appointments at local hospitals. A visiting health care professional said the staff were providing care in accordance with people's needs. A visitor told us, "They're on the ball getting additional support" and a person living in the home told us, "If I'm unwell they get a doctor."

We looked at staff training and support. Most people who lived at Cambridge Court and their relatives told us staff were trained sufficiently to meet their care needs. "They're well trained" and "Enough training yes" were some of the comments we received. Training was given in a number of areas, such as food hygiene, manual handling, health and safety, fire safety, infection control, record keeping, safeguarding and the mental capacity act. Staff told us they had access to training via a new e-learning system as well 'face to face' training. The training matrix was viewed which showed what training had been completed. A number of staff told us they had not completed safeguarding or mental capacity training recently, which was evidenced by the training matrix. When discussed, some staff were unclear of their responsibilities in these areas. This meant that people were at risk of receiving care from staff who did not have the knowledge and skills to carry out their role effectively. The manager told us that more training dates were being planned and training was an area that was being developed.

We looked at four personnel files to establish how staff were inducted into their job role. Staff told us they felt they had received sufficient induction to their role, for example by shadowing a more experienced staff member. There was no evidence of a robust induction for new staff within the files viewed and the Care Certificate had not been implemented within the homes induction process. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. Two staff files viewed included a tick list induction and two did not contain any evidence of induction. The manager told us new staff work with an experienced member of staff until they know people living at the home and their individual care needs and routines. We were also told that the e-learning system has a module that includes the common induction standards, however the training matrix did not reflect completion of this course. There was a risk that staff had not received an induction to prepare and support them in their job role.

Staff we spoke with told us they felt well supported and received regular supervision and we observed records of these supervisions. Staff meetings were also held to enable staff to discuss any concerns and receive guidance and updates regarding their roles and the running of the home. There was however no system in place to ensure staff received an annual appraisal. The provider confirmed that appraisals were not currently being completed and that they would review this to ensure staff were well supported.

Not ensuring staff are appropriately supported to carry out their roles and responsibilities, through training, induction and appraisals, is a breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked to see if the service was working within the legal framework of the 2005 Mental Capacity Act (MCA). This is legislation to protect and empower people who may not be able to make their own decisions, particularly about their health care, welfare or finances. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken. The Care Quality Commission (CQC) is required by law to monitor the operation of DoLS. Staff we spoke with were not always aware of the requirements of the Mental Capacity Act and most told us they had not received training in relation to this. The training matrix provided evidence that half of the staff team had received training in relation to mental capacity. The manager told us they had attended training in relation to DoLS last year, however, was unaware of current guidance in relation to assessing peoples need for a DoLS application. No applications had been made for people living in the home. Following discussion with the manager and specialist professional advisor regarding current guidance for applications, it was agreed that there may be some people living at the home for whom a DoLS application would be required as there a risk that people's

Is the service effective?

liberty could be restricted unlawfully. The manager agreed to review this and since the inspection has confirmed updated training has been secured and appropriate applications will be made.

During discussions with staff they told us they always asked for people's consent before providing support and we observed this taking place during the inspection, such as when staff were supporting with meals or personal care. The manager informed us staff sought consent from people and their relatives and involved them in key decisions around daily life and support. Relatives we spoke with agreed with this and a relative stated, "Communication is good, we feel involved, part of the team looking after (relative)." Care files viewed evidenced that people had been consulted about their care and agreed to the support plans in place. When people were unable to make decisions, there was evidence that relevant people had been involved in making best interest decisions. For instance, a GP, family and pharmacist were involved in decisions regarding administration of covert medicines.

Some care files viewed showed that decision specific capacity assessments were completed in relation to finances and covert medicines for example, but they were not evident in all cases. It was not always clear as to whether a mental capacity assessment had been completed to determine whether people had the capacity to make specific decisions, such as using bed rails. The manager agreed to look at their procedures around recording these assessments.

We observed a person being supported to the bathroom for assistance with personal care. The person told staff they did not want to go to the bathroom; they wanted to go to the shops. In order to encourage the person to go with them, the staff then told the person they were taking them to the shops. This is not in line with best practice with regards to gaining consent for care and treatment.

We recommend that the provider considers current guidance and legal requirements in relation to the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards, and takes action to update its practice accordingly.

We observed the lunch time meal. Some people chose to sit at the dining tables whilst other people chose to sit in lounge chairs with a table in front of them. Dining tables were laid with a table cloth and cutlery. People were offered water, orange juice and tea before lunch was served. Staff asked peoples consent before supporting them to wear a dignity apron if they were required. Staff supported and encouraged people individually in a respectful and dignified manner and were quick to respond when people required support, such as to cut up food.

We spoke with the chef and they told us they were kept informed of people dietary requirements and preferences by the nurses and also talking to people to ask their opinions and suggestions regarding meals. There was no set menu that the chef followed and people were asked each morning which of the two choices they would like for lunch.

People we spoke with told us the food was very good and that there was always a choice of meals. We observed the choice of meals was written on the boards in the two dining rooms. People told us their preferences were considered and one person told us, "Food is quite good, if I don't like anything they'll offer me something different." This was observed on the day as the chef saw a person push their plate away untouched and asked the person if they would like something else, which was then provided. Meals were well presented and hot and people were given time to enjoy their meals. Feedback from relatives regarding the food was positive and one relative told us their relative received meal in a pureed form and was still well presented.

Care files we viewed showed that people's nutritional risk was assessed and appropriate support measures implemented, such as regular weight monitoring, referrals to health professionals such as a dietician and fortified diets provided when necessary in order to maintain people's nutritional wellbeing.

We observed the environment of the home and found that the signs or decoration were not adapted to meet the needs of people living with dementia or promote their independence. For example, the doors were all the same colour so bathrooms could not be easily identified and all corridors looked the same. This does not support people living with dementia to orientate themselves or promote their independence. People living at the home told us the walls were bare and it would be nice to have pictures or books to look at. The outside garden and seating area was next to the car park. This meant that not all people were able to access the area independently. We observed that the garden area contained items such as baths and toilets

Requires improvement

Is the service effective?

which the manager advised were waiting to be disposed of. Although people told us they regularly went out for the day on the minibus, they rarely accessed the garden. One person told us, "People need a garden, it would be nice to go outside." The provider told us they would look at ways of improving the environment to better meet people's needs.

We recommend that the provider explores the relevant guidance on how to make environments used by people with dementia more 'dementia friendly'.

Requires improvement

Is the service caring?

Our findings

Overall we observed positive interactions between staff and people living at Cambridge Court. Staff were mainly warm, kind and caring when interacting with people, though some interactions were abrupt, for instance we heard one staff member telling a person to "Uncross your legs." We asked people if they were treated with kindness and respect and they confirmed this by stating "They're kind they know me well" and "They're kind and caring, treat me properly with respect." Relatives reported the staff were caring and interacted well with their loved ones. They also told us the care was very good. We were told, "Staff are so nice and friendly. Their approach is lovely so kind and caring" and "Can't fault staff they're all lovely, very, very caring."

We observed staff sitting and chatting with people during the day and encouraging people to sing and dance in the afternoon, creating a light, enjoyable atmosphere.

People we spoke with told us they had not been involved in their care plans, however those care files we viewed showed that people's care plans had been discussed with them or their relatives and that they agreed to the care plan in place. Relatives we spoke with confirmed that they had been involved in the development of their relative's plan of care and we observed documented meetings between staff and relatives to discuss care plans. Care plans viewed included brief details of a person's life history and preferences to enable staff to understand people and their experiences.

Personal care activities were carried out in private and we observed staff offering reassurance when supporting people, such as when assisting a person to mobilise and ensuring their comfort and wellbeing before attending to someone else. We observed people's dignity and privacy being respected by staff in a number of ways during the inspection, such as staff knocking on people's door before entering and referring to people by their preferred name. We did, however, observe that a person in the lounge had been sick. The person's dignity was not protected as the bowl was left on a table in front of them for a significant period of time until we asked the staff to remove it. We also noted that the maintenance office was accessed through a bathroom used by people who lived at Cambridge Court. This meant there was a risk of people's privacy not being maintained and the provider agreed to review this to ensure people's privacy and dignity would be maintained at all times.

We observed relatives visiting throughout the day and the manager told us there were no restrictions in visiting, encouraging relationships to be maintained.

People's care plans were stored securely within an office, however during the inspection we observed various documents in communal areas within the home. These records contained people's private and personal information, such as names, dates of birth, nutritional needs and records regarding care and support that had been provided each day. This meant that private information about people living at Cambridge Court was accessible to others living there, staff who did not need to know and visitors. This meant people's privacy and dignity was not always being respected as their records were not stored securely.

We recommend that the service reviews its procedures regarding storage of records to ensure people's confidentiality is maintained in line with current legislation and guidance.

The manager told us four people living in Cambridge Court had an advocate involved in their care and the service user guide contained information on advocacy services available to people who may not have relatives to support them.

Requires improvement

Is the service responsive?

Our findings

Care files we viewed contained an assessment of people's needs which were carried out prior to them moving into the home to ensure the service could meet the person's needs effectively. We looked at how people were involved in their care planning. People we spoke with were not always aware of the written care plan but were happy with the support they received and the care files we viewed did evidence that people's care and treatment had been discussed with them or their relative. Relatives told us they were involved with the planning of their relatives care and were kept informed of any changes by staff. One visitor told us the staff worked with them as a team to support their relative.

We looked at people's care files and saw that people had a plan of care which contained detailed information regarding people's care needs, such as mobility, skin integrity, breathing, personal care, communication and nutrition. Care plans were person centred and included information regarding people's preferences. This enabled staff to get to know the person and provide care specific to the individual. One care plan viewed gave specific guidance to staff on how to support a person displaying behaviours that challenge and how to de-escalate a situation to ensure the person's safety and wellbeing. Reviews were detailed and meaningful and identified changes in people's health and care needs were updated within the plan of care. For example, one person had recently been prescribed a new medicine to help with breathing and this had been included within the care plan.

Some people told us they could choose how to spend their day. For example, some people chose to sit in the lounge, whilst other people preferred to watch television in their rooms. We observed staff visiting people in their rooms to check their wellbeing and reduce isolation. We asked people if they had a choice regarding the gender of care staff who supported them with their personal care needs and people told us they did.

Staff told us people were able to get up of a morning when they chose and care plans viewed included people's preferred routines in relation to getting up each morning. We, however, observed a number of people in the lounge early in the morning and some people we spoke with told us they did not always have a choice as to when they got up. Three people told us they were not able to lie in bed when they wanted and were woken up by staff in the morning. This was raised with the manager who agreed to speak to staff to ensure they adhered to people's individual preferences so they have choice and control over their lives.

Failing to provide care that meets people's needs and reflects their preferences was a breach of Regulation 9 (1) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with told us they were informed of any changes within the home, including changes in people's care needs. This was achieved through staff handover and reading the communication book and daily diary, as well as people's care plans. People we spoke with told us they were happy with the support staff provided to them and that staff knew them well.

We asked people to tell us about the social aspects of the home and how they spent their day. An activities co-ordinator was employed by the service and they regularly supported people to go out of the home in the mini bus, which people told us they enjoyed. People told us there was very little activity within the home other than the television. We observed the television was on in both lounges during the morning and people did not appear to be watching it. In the afternoon music was played and staff encouraged people to sing and dance. Instruments were available for people to use whilst listening to the music. The activities co-ordinator had created individual activity care plans for people and recorded their interests, participation in trips out and whether they enjoyed it. There was no planned programme regarding activities available within the home and no records of when they took place. The service did not provide appropriate activities to engage and stimulate people living with dementia. The manager agreed to look at how activities within the home are provided and recorded to ensure people have access to regular activities in line with their social interests and preferences.

The home had a policy and procedure for managing complaints. Information regarding the complaints process was available to people within their service user guides and the manager agreed to display a copy in a communal area. People we spoke with told us they knew how to make a complaint, felt able to speak to staff and were confident they would be listened to. One person had raised a

Requires improvement

Is the service responsive?

complaint which had been resolved to their satisfaction. We viewed records regarding complaints, one of which was on-going and others had been resolved in line with the home's policy.

Arrangements for feedback about the service included satisfaction surveys for people who lived at the home and for relatives, as well as residents and relative's meeting. We were shown feedback from these surveys and they were generally positive.

Requires improvement

Is the service well-led?

Our findings

A manager had commenced in post and made an application to be the registered manager. This application was being processed at the time of the inspection. We asked people their views of how the home was managed. Feedback from people living at the home, visitors and staff was positive. Visitors told us they felt involved in the care provided to their relatives; that the manager knew everything that was going on and communication with families was good.

During the visit we looked at how the manager and provider ensured the quality and safety of the service provided. We saw that there were a range of audits (checks) completed, such as medicines, care plans, fire safety, infection control, nurse call bells, mattresses and health and safety. Not all audits showed action had been taken where issues had been identified. For example, the infection control audit highlighted ripped fabric on chairs, the manager told us these had been disposed of but the audit tool did not reflect that this had been completed. The manager agreed to look at ways of improving how action taken was recorded.

Contracts for services and equipment to the home, such as call bells, hoists and slings were also in place. We viewed an audit tool used to monitor accidents within the home. This was brief and only included the number of falls which had occurred. The manager told us each fall was reviewed and risk reduction measures implemented, however these were not reflected on the audit. The manager told us they were in the process of creating a new tool which will be more detailed and look at potential trends or causes of accidents.

We found on inspection that some issues requiring the home to notify the Care Quality Commission (CQC) had not been made. These included notifications regarding allegations of abuse. The manager was unaware that these notifications were required, however had made appropriate referrals to local safeguarding team and incidents had been investigated. The manager told us they would ensure such notifications would be made in the future. The manager had completed other necessary notifications and agreed to ensure all required notifications were completed.

The provider, manager and people living in the home told us the provider visited regularly. The provider kept up to date with the running of the home and told us they completed checks but there was no system in place to record the findings from these visits. Therefore they had not picked up on the concerns we identified during this inspection. The manager agreed to look at ways of recording future visits and checks made.

Failing to ensure effective systems and processes were in place to assess, monitor and improve the safety and quality of the service was a breach of Regulation 17(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were systems in place to gather feedback regarding the service. We viewed records of residents and relatives meetings. Relatives told us they attended meetings to discuss the running of the home and any changes. One relative told us they were unable to attend the last meeting held, however the manager provided them with verbal feedback from the meeting to ensure they were kept informed. People told us they felt able to discuss any concerns with the manager.

We were shown completed satisfaction surveys and the feedback regarding the home was generally positive. However where an issue was raised, there was no record of any actions taken to address the concerns. The manager agreed to review how this was recorded.

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 9 HSCA (RA) Regulations 2014 Person-centred care **Failing to provide care that meets people's needs and reflects their preferences was a breach of Regulation 9 (1) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Failing to ensure effective systems and processes were in place to assess, monitor and improve the safety and quality of the service was a breach of Regulation 17(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Not ensuring staff are appropriately supported to carry out their roles and responsibilities was a breach of Regulation 18 (2a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Not ensuring appropriate care and treatment was planned to meet people's needs is a breach of Regulation 12 (a) (b) of the 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

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 **Not having effective systems and processes in place to prevent abuse of service users was a breach of Regulation 13 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**