Four Seasons (No 9) Limited

Cypress Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection was unannounced and took place on 16, 17 and 18 October 2017.

Cypress Court Nursing Home was previously inspected in January 2016 when it was found to be meeting all the regulatory requirements which were inspected at that time.

Cypress Court is a purpose-built residential and nursing home in Crewe, Cheshire. The home can accommodate up to 60 older people, it has a lift to the first floor and an open plan reception area. There are large lounge areas and a dining room to each floor. At the time of our inspection the service was accommodating 49 people. Some refurbishment has recently taken place.

There was a registered manager in place at the time of the inspection. 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 a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During the inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 related to: person-centred care, need for consent, safe care and treatment, safeguarding service users from abuse and improper treatment; receiving and acting on complaints, staffing and good governance. You can see what action we told the provider to take at the back of the full version of the report.

Procedures for protecting people from abuse and neglect were not sufficiently established or operated effectively. Staff reported a culture of fear of reporting or that concerns were not followed up when they did so.

We saw that accidents/incidents were not always recorded, investigated or followed up robustly.

Several people had experienced a high level of weight loss during 2017 and we saw that malnutrition risk assessments were not completed accurately. Although actions had recently been taken to review this matter, it was not identified in a timely manner and therefore people were left at risk of continued weight loss.

We found that medicines were not always managed satisfactorily; for example, we identified some discrepancies in stocks; that medicines were not stored as required and that manufacturer's instructions were not always followed.

People using services, visitors/relatives and staff told us that they felt there had been insufficient staff to meet people's needs although this had improved recently as staffing levels had been increased.

Risk assessment and a record of people's consent was not always in place, for example, for the use of bedrails. We found that call bells were not always within reach leaving people unable to summon help in an emergency.

The registered manager had not carried out supervision or appraisal with staff as required.

Monitoring charts that were put in place were not completed effectively, for example for fluid intake to monitor the risk of dehydration and for positional changes, to reduce the risk of pressure damage to skin.

People's likes, dislikes and preferences were not sufficiently reflected.

We found that the home had some systems in place to assess and monitor the quality of service that people received. However, these systems had not been sufficiently robust or managed effectively to identify the issues raised within this inspection.

People had access to a choice of menu. Records also showed that people had access to a range of health care professionals subject to individual need.

We observed staff interacting with people using the service in a caring manner although we observed that a person was spoken with abruptly on one occasion. Management took appropriate actions immediately and the member of staff offered their apologies.

Advocacy services were available for people who may need this support.

The overall rating for this service is 'Inadequate' and the service is therefore 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.

During the inspection the customer experience regional manager took prompt action to address concerns that were raised and engaged well with the inspection process. Immediately following this inspection the

provider put in place alternative arrangements for day to day management of Cypress Court and we were subsequently informed that an internal investigation would to be carried out.

The provider took on board the findings of this inspection and additional regional management support was put in place to drive improvements forward quickly. A substantive action plan was submitted and weekly updates are being provided.

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.

Medicines were not always stored or managed safely.

Safeguarding systems and processes did not provide adequate protection to people using the service.

Risks were not managed or mitigated effectively.

Is the service effective?

Requires Improvement

The service was not effective.

The principles of the Mental Capacity Act 2005 were not always followed.

Significant weight loss within the service had not been addressed in a timely manner leaving people at risk of further weight loss.

Staff had not received regular supervision or appraisal.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us that staff were caring but did not have enough time.

Staff interaction was mostly caring but we observed one person spoken with abruptly.

Advocacy services were available if people needed them.

Is the service responsive?

Inadequate

The service was not responsive.

People were not always receiving care when they needed it.

Care plan records, risk assessments and supporting

documentation were in need of review to ensure that they contained all the necessary information to assist in the delivery of person centred care.

Systems and processes had not been established or operated effectively to identify, receive, record, handle and respond to complaints.

Is the service well-led?

Inadequate

The service was not well-led.

The registered manager did not provide effective leadership and direction.

Leadership and governance arrangements were not robust as systems and processes to safeguard people and assess, monitor and improve the quality and safety of the service provided were ineffective.

Cypress Court

Detailed findings

Background to this inspection

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

This inspection took place on 16, 17 and 18 October 2017. The inspection was unannounced and was carried out by two adult social care inspectors, an expert by experience and a specialist nurse advisor on the first and third day of the inspection and by two adult social care inspectors on day two. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. A specialist advisor is someone with particular professional knowledge and expertise. The service was aware of our visits to continue the inspection on the second and third days.

We reviewed information which the Care Quality Commission already held about the provider. This included previous inspections and statutory notifications we had received. A notification is information about important events which the service is required to send us by law. We invited the local authority to provide us with any information they held about Cypress Court Nursing Home. We were advised that they had carried out a quality visit to the service in August 2017 although the provider had not yet received their report. Their visit had identified the need for some improvements.

We were also aware that the local authority had met with the provider to discuss referrals that had been made under safeguarding procedures and following these referrals a nominated social worker was allocated to carry out reviews of care received by people using the service. We contacted the nominated social worker who advised that the reviews had begun and that she had made the service aware of some actions that needed to be taken. We were aware that the service was being supported by the provider's regional management team. We took any information the local authority provided into account.

We used a number of different methods to help us understand the experience of people who used the service. During the inspection we spoke with 10 people who lived at the home and eight relatives/visitors, to seek their views. We spoke with 23 members of staff including the registered manager, deputy manager, two activity co-ordinators, four nurses, a chef, three members of the regional management team, a visiting home

manager and 10 health care staff. We also spoke with two visiting health and social care professionals.

Some people at Cypress Court were living with dementia and were unable to tell us about their experiences, therefore we used the Short Observational Framework for inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

We looked at the care records of six people who lived at Cypress Court, medicines records for 15 people and inspected other documentation related to the day to day management of the service. These records included: staff rotas, quality audits, accident/incident records, medicines records, training and induction records, supervision records and maintenance records. We toured the building including bathrooms, and with permission spoke with some people in their bedrooms. Throughout the inspection we made observations of care and support provided to people in the communal areas.

Inadequate

Is the service safe?

Our findings

We asked people if they felt safe and well cared for. Comments included "Oh, yes I do", "Yes, sort of", "It's OK, not bad" and "We put up with a lot, staff are too young". Visitors' comments included "From what I've seen good", "If you've got dementia not so good, they are ignored repeatedly" and "Home has got issues".

The provider had policies in place for safeguarding adults at risk of harm from abuse or neglect and for whistleblowing. Staff spoken with told us that they had received training with regard to safeguarding adults although one recently recruited member of staff told us they had not yet been shown how to access e-learning and did not know where to access safeguarding policies.

A member of staff told us of some serious concerns they were aware of. They thought some had been reported to management but were unclear whether others had. All of the issues mentioned would have required investigation with some requiring referral under local safeguarding adults protocols. We were told by the staff member that they had not reported these concerns due to "fear of repercussions" and that when they had done so in the past "nothing had been done". The concerns were brought to the attention of the registered manager and customer experience regional manager and immediate action was taken.

Staff were aware of whistle-blowing procedures however; while one staff told us that they felt able to whistle-blow, had done so and were listened to several told us that they did not feel able to do so.

A file relating to staff supervision included a statement about an incident involving a person using services, however the registered manager confirmed that the incident had not been recorded or investigated as required.

In the care files reviewed we found several examples of body maps which noted unexplained bruising. The body maps had not always been fully completed with the person's name, measurements of the injuries etc. and there was not always corresponding information noted within the care file, accident/incident records, safeguarding referral or details of investigation available. For example, we saw a body map which detailed bruising and swelling with no explanation. We brought this to the attention of the registered manager who confirmed that there was no accident/incident or referral to the local authority safeguarding team on file relating to these injuries. Therefore we could not be sure that people were adequately protected from abuse and harm.

These issues were a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had failed to establish and operate effectively a system and process to prevent abuse of service users.

People told us that they did not always get their medicines at the time they needed them. Comments included "Take painkillers for example. Needs to be every four hours. They are sometimes late. Say 11p.m. instead of 9 p.m.", "Pain relief for my (condition). I buzz, they either don't come or I'm told too busy so wait" and "It can be late sometimes".

We reviewed the safe management of medicines and found there were significant shortfalls.

We found that topical applications were not effectively managed, applied as prescribed and were not recorded/applied in line with the provider's policy. One person told us that staff did not know what they were doing with regards to the creams they were prescribed for various parts of their body. We reviewed records relating to the application of these creams which confirmed that they had not been administered or stored as prescribed. For example, one cream that needed to be stored at temperatures below 15°C was not stored in the fridge. If medicines are not stored at the correct temperature this can affect how well they work.

Some medicines were administered by a patch applied to the skin. We saw that manufacturer's guidance stated a transdermal medication should be applied weekly and it was not to be applied in the same position for 3-4 weeks. However, a chart indicated only two positions were used, left and right chest, therefore the required interval for positioning was not being followed.

We saw that one medicine, adrenaline, was stored in an "Anaphylactic Shock Kit". Regulatory guidance states that this medicine can be obtained via a requisition, be administered in an emergency to save life and would not need to have a prescription issued. In this circumstance 'It is important that staff working in care homes stocking adrenaline have appropriate anaphylaxis training'. The registered manager could not demonstrate this to be the case. Furthermore, we found that three ampules of adrenaline had expired in April 2017. We saw that medication audits carried out by service were not sufficiently robust to have identified this out of date medicine or to ensure that appropriate policies and procedures were in place for its use.

We checked the stock balances for some medicines and found discrepancies between how much had been given and how much stock remained. This meant that it was impossible to be sure if medicines had been administered in line with their prescription.

Some medicines were prescribed to be taken pro re nata (PRN) which means when necessary. However there was no PRN protocol in place to provide guidance for staff in this regard.

We were told by one person that they did not get pain relief medicine at night at the time they needed it. They explained "Sometimes as late as 11p.m. – I need it earlier". We reviewed the MAR records and found that Paracetamol was prescribed to be taken two tablets four times daily when required. The MAR record had pre-printed times of 09.00; 13.00; 17.00 and 21.00. There was no PRN protocol in place to detail the exact time the medication was administered.

The person was also prescribed two other pain relieving medicines but none had been administered during the current cycle. There was no pain management tool in place. We discussed these findings with the registered manager and customer experience regional manager who took immediate action to schedule a pain management review with the GP. They also confirmed that a process had been implemented to ensure that the person was offered his medication when needed.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had failed to provide care and treatment in a safe way.

We reviewed how risks to people were managed. We found that potential risks had not always been fully recorded in people's care records and appropriate risk assessments were not always evident. For example, one person had refused the diet recommended by the Speech and Language Team (SALT). We saw from

their file that SALT had provided guidance in May 2017 for supporting the person with their meals. The guidance stated "Careful hand feeding of safest consistencies accepting the risk of aspiration". It also provided instructions of symptoms staff should be observant for and that if those symptoms occurred intake would need to stop whilst the person recovered.

We observed this person was served their meal in their bedroom with staff leaving the room immediately. Staff confirmed that this was normal practice. This meant the guidance from SALT was not being followed and the person was at risk of choking. A risk assessment for choking on file assessed the risk as "low", despite the guidance on file. We raised our concerns with the registered manager and customer experience regional manager who took immediate action to contact SALT for reassessment and confirmed that the person would be supervised during meals until the reassessment had taken place.

During the inspection we observed one person had remained in their bed each day. Staff confirmed that this person did not transfer out of bed and usually ate their meals in bed. We reviewed the section of this person's care plan relating to nutrition which stated. "Puts herself at risk of choking by refusing to sit up for meals". There was no evidence of a risk assessment around this decision. The member of staff spoken with said they had not had time to write a risk assessment or consider the person's capacity to make this decision.

The risk of malnutrition was assessed using a Malnutrition Universal Screening Tool (MUST). Weights were recorded on a matrix from which we saw that several people had experienced significant weight loss and that MUST records had not been completed appropriately leaving people at risk of ongoing weight loss. This is discussed further in the effective section of this report.

We also saw that risk assessments had not always been completed for the use of bed rails, despite audits completed by the registered manager noting that they were. We raised this concern with the customer experience regional manager who took immediate action to complete a service review for all people requiring the use of bed safety rails.

These issues were a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had failed to provide care and treatment in a safe way.

Some people living at Cypress Court, visitors and staff told us that they felt that there had not always been enough staff although this had improved recently. Comments included "It wasn't good before but now there is enough staff", "Better now than a couple of months ago", "I've been shouting for ages and no-one comes" and the manager had been "Responsive when need more staff for anyone that asks".

The registered manager explained that the service was staffed as if the home was full at the present time. We saw from care files that people's dependency levels were recorded using a scoring system which was then linked to an assessment tool called CHESS to determine staffing levels. Some staff told us that staffing levels were increased to meet people's needs whilst others said that they were not.

During the inspection staffing levels generally appeared sufficient to meet people's need. However, staff, people using services and visitors all raised concern that lack of continuity of staff, staffing levels and that staff not being sufficiently aware of people's needs impacted upon the care received and staff's ability to meet needs in a timely manner. Care at times appeared task focussed with some staff observed wandering around rather than using that time to talk with people. Staff raised concern that the skill mix was not being managed well. We were told that senior and more experienced staff worked downstairs whilst newly recruited staff worked upstairs where people were more dependent. Staff also expressed concern at the lack

of continuity of care due to the high use of agency staff.

Comments included "My leg is dressed differently by all staff, haven't got a clue. It's a nightmare" and "Staff appear rushed all the time, communication is not passed on". Staff told us "It affects residents and us. We get tired. It's a vicious circle", "We snap at each other" and "It is upsetting when you haven't time". During the inspection we heard an agency nurse asking a person whether their dressing needed changing "today or tomorrow", the person was able to tell them it was tomorrow but the nurse seemed unaware of the requirements of the wound care plan.

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had failed to ensure that there were sufficient numbers of suitably qualified, competent, skilled and experienced staff employed to meet the needs of people using the service.

The registered manager informed us that there was high use of agency staff at the present time, some 240 hours of agency usage in the previous week. We saw that there was particularly high use of agency nursing staff. When agency staff are used the service should make checks with the agency to ensure that the person is appropriately qualified, trained and that appropriate recruitment checks have taken place. The agency will provide a profile for each worker.

When the agency worker attends the service they should also receive an induction. We asked to see profile and induction records but these could not be found. We asked about records for the agency nurse on shift that day and were informed that a profile was not on file and although the worker had received guided orientation of the building, an induction record had not been completed. The deputy manager took steps to address this later in the afternoon. We were informed following the inspection that agency staff had been booked in advance to ensure consistency. We recommend that the provider reviews the process for confirming the suitability of agency staff and for robust induction.

We saw that there was a process to record accidents and incidents and that the provider had a policy in place to manage such events. Details of accidents/incidents were recorded on a computer system called Datix, which also provided oversight at regional management level. All staff spoken with were able to describe the process to follow with regard to reporting accidents/incidents and were aware of how to access the policy. We reviewed the file containing records relating to accident and incidents which contained printed records along with a hand written index. However, we became aware during the inspection of accidents/incidents for which no record had been created.

Bedroom fire assessments and personal evacuation plans (PEEPs) were seen for each person. The fire training register was viewed, last documented as delivered in April 2016. A training matrix showed fire safety training to be 96% compliant.

The fire log book showed that weekly and quarterly fire safety checks were completed. A fire evacuation plan was located by the entrance. We saw that appropriate testing had taken place for fire safety equipment, gas and electrical installations and portable appliances.

The environment was visibly clean and tidy. Recent refurbishment had taken place and new furniture delivered. The home was generally free from malodours. However, we saw that a pile of pressure cushions had been left on the floor and a chair in the lounge area. Several of these were stained and in need of cleaning. Staff were observed wearing personal protective equipment appropriately.

We looked at a sample of three staff files to ensure that the staff that were recruited were suitable to work

with vulnerable people. The files were well organised and contained records relating to each staff member. Full pre-employment checks were carried out, application forms had been submitted, confirmation of identification was evidenced in files, suitable references had been obtained and Disclosure and Barring Service (DBS) checks had been suitably carried out. We saw that checks had been made to ensure that nurses' registrations were up to date. However, we saw from one file that there had been a gap in employment but there was no evidence that this had been explored. We would recommend that the provider explores and clearly documents discussion around employment gaps within interview records.

Requires Improvement

Is the service effective?

Our findings

We asked people living at Cypress Court if they felt their care and support to be effective. Comments included "I'm looked after I think". Some people said that the regular staff knew them well but agency staff did not as they were "thrown in at the deep end" and that staff carried out "basic care" well. Relatives commented "We're pleased with how (Name) is doing here, (Name) is eating better".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decision 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).

We spoke with staff about their understanding of mental capacity and DoLS some staff told us that they had not heard about decisions specific mental capacity assessment or best interest whilst others were able to demonstrate good knowledge in this area.

At this inspection we found that the service was not always working within the principles of the MCA and DoLS. A summary headed DoLS review dated 26/09/2017 did not provide information as to the date when referrals were requested, authorised or required renewal. The summary identified five DoLS authorisations were in place however documentation was found to be inaccurate. Following the inspection we discussed this with the resident experience lead who confirmed that a review of DoLS would take place as the summary had been found to be inaccurate.

On the first day of the inspection we saw a person sitting up in bed with bed rails in place; their call bell was out of reach. The person told us that they would like to sit in their armchair but needed a cushion so it was not uncomfortable. On reviewing the person's care file we saw that there was no risk assessment or consent documented for the use of bed rails. We raised this matter with the management team and a mental capacity and consent form were completed.

However, on reviewing this documentation and following conversations with the person on the second day of the inspection during which they told us "I'm trapped here" and "They can take that thing away", we felt that the mental capacity and consent documentation were not accurate. We noted that this person's call bell was once again out of reach on day two of the inspection. We spoke with the home manager and customer experience regional manager about our ongoing concerns and immediate action was taken. A full service review was also carried out to identify any other people with bed rails in place to ensure that appropriate risk assessments and consent was in place or MCA followed.

We saw that care plan agreement forms within the care files had not always been completed or signed. For example, we saw an agreement form which was blank although the care plan for Rights, Consent and

Capacity Needs noted that the person wished to be central to all decision making processes around their care and social needs. Also, that they wished to be involved in the monthly review of their care plans and risk assessments. We could see no evidence of the person's involvement in drawing up the care plans or monthly review or consent for their plan of care.

These issues were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had failed to provide care and treatment with consent of the relevant person.

Catering was provided by an external company, the same chefs attended for consistency. There were two dining rooms, one on each floor, and people could choose to have their meals served in their rooms if they wished. We saw that breakfast was served and drinks available in a timely manner. However, we were told that a cooked breakfast was only offered as a "treat". The customer experience regional manager advised that a cooked breakfast should be available at all times and immediately contacted the external provider to ensure that a cooked breakfast would be available each day.

People expressed varying views on the food served, some people told us "Food is good, there are choices", "Basic but choice" and "Yes, it's OK, I like it". Others commented "It's not so good, powdered mash", there are two choices, you have to have one of them or go hungry", "you can't change, they go mad told to shut up, you don't say anything" and "food is horrible. It makes me sick". One person said that if they needed support with their meal "We have to wait".

We saw that there was evidence of significant weight loss recorded for a number of people in 2017. For example, records noted losses of 7.7kgs between March and October; 9.4kgs between April and September; 10.3 kgs between February and September and 8.15kgs between February and October. Although this situation had recently improved as more robust monitoring of nutritional needs and appropriate dietetic referrals had been put in place it was not identified in a timely manner and therefore had left people at risk of further weight loss.

We found that MUST records had not been completed accurately and that, although people's care plans stated they should be weighed on a monthly basis this did not always happen.

These issues were a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had failed to provide treatment in a safe way.

We reviewed the Essential Course Compliance matrix provided. This showed compliance of 100% for some courses, including using bed rails; some were much lower, for example information governance, 83%, care of medicines advanced 75% and introduction to health and safety 85%.

Additional training was provided to meet specific care needs such as catheter care and percutaneous endoscopic gastrostomy feeding (PEG). Some staff told us that they felt well trained to do their job and support people using services however one mentioned that they did not like e-learning as "it's just the click of a button" and also that they had asked for training in stoma care but that they were "told no" even though the training was available.

We asked about the induction that staff received and saw evidence of an induction booklet in one of the staff files reviewed. Some staff told us that they felt they had received appropriate induction and that it prepared them for their role. Comments included "Yes, good, everything explained to me" and "Yes I was prepared for the job".

However, some staff told us that they felt the induction for new starters was insufficient and not managed effectively, feeling that they were included in staffing numbers too soon and that they were "thrown in at the deep end". We asked a more recently recruited member of staff about their induction and were told "I was thrown in at the deep end. I was doing everything, no time to induct properly". We were told that they had not been shown how to access e-learning and had never met the manager.

During the inspection we saw a staff member working on their first day of induction, when asked the registered manager was unable to tell us their name. We also identified that a different member of staff on the first day of their induction had been carrying out manual handling procedures and personal care which they should not have been. The registered manager did not have sufficient oversight of induction and deployment of these staff.

We asked the registered manager about staff supervision and appraisal and they told us that staff received one to one supervision every three months and an annual appraisal although acknowledged these were not up to date. Staff comments about supervision included "I haven't had one for a while. Can't remember the last one", "Been a while, not this year". We reviewed the supervision matrix and records provided and found that the matrix was not an accurate record as there were records for some sessions which did not appear on the matrix and some that were on the matrix did not have corresponding records.

Annual appraisals were marked as having been completed for only twelve staff.

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person failed to ensure that staff had received appropriate training, supervision and appraisal to enable them to carry out the duties they have been employed to perform.

We observed one person who looked unkempt, hair not combed and their eyes were sticky. Following conversations with the CHAP and staff involved it was discovered that personal care for that person had been "forgotten" that morning. The member of staff explained that the care assistant they were working with had been unwell and had left the building. They were then paired with a new member of staff and this had resulted in them overlooking the person. We raised our concerns about this with the registered manager and customer experience regional manager who took immediate action to provide personal care and to review staff deployment.

We saw that people had access to other health services such as GP, and that action was taken in response to concerns, for example we saw that people were referred to the doctor for urinary concerns, constipation and for regular refusal of medicines. People told us they could see healthcare professionals and that staff made appointments for them. Comments included "I can if I need one, that's good" and "Yes we get looked after here, if I need anything I'm supported". However one person told us "You are put into a book to see GP, we have to believe them, then you ask where the doc is he's gone".

We observed a person coughing when eating independently; we brought this to the attention of the registered manager and customer experience regional manager who took immediate action to arrange for referral to SALT.

Requires Improvement

Is the service caring?

Our findings

During this inspection we asked people if they felt they were supported in a caring way. People told us ""Staff are OK, nothing wrong with them", "Lovely girls, I'm looked after I think", "The carers here are marvellous to me, they care for me very well and "Yes they are kind". Comments from staff included "It's a good place to work, I like caring for the residents".

We spent time with people using the service and their visitors during our inspection. In general people told us that staff were caring but that they didn't have enough time. Staff members also raised concern that they did not have sufficient time to talk to people. Comments included "It's like a production line", "You are on a timer all of the time, you don't have time to ask questions like how are you". However, we were told that this had improved recently.

We observed interactions between staff and people which were mostly positive and caring we also saw that at times care was task focused. Staff used people's names and supported people with meals in a dignified way. For example, we observed a staff member supporting a person with their breakfast, seated beside them chatting and interested in the conversation taking place. We observed one person could not read their letter; a care assistant put the light on and politely asked if the person would like her to read for them. However, on one occasion we observed that a carer's approach was abrupt when asking a person questions. We discussed this with the manager and customer experience regional manager who raised this with the staff member concerned.

Overall we found that people's dignity and privacy were respected during the inspection. Staff spoken with had an understanding of the need to treat people in a dignified manner. Staff told us of an occasion when they had reminded another staff member of the need to knock before entering a room as they had been disturbed whilst they were providing personal care. We observed a person's door was left open whilst personal care was being provided as the care assistant asked for help finding cream.

The registered manager told us that advocacy services were available for people who needed them although details were not displayed within the building. We saw evidence that this service was available from care records and a person was visited by an IMCA during the inspection.

Staff were aware of the need to maintain confidentiality. We saw that care plans were kept securely in locked cupboards. However on the first day of inspection we noted that some personal information was displayed on notice boards on both floors. This was brought to the attention of the registered manager and the information was removed immediately.

During the inspection we saw there were several visitors to the home. People told us that relatives and visitors were able to visit at any time without restrictions and were made to feel welcome. Visitors told us that staff were respectful to them and their relatives. Comments included "And very pleasant to me, hello (Name) are you OK)?", "Yes, always knock to come in, they ask first".

Inadequate

Is the service responsive?

Our findings

Comments from people living at Cypress Court included "I'm waiting to go upstairs, I've asked a few times, staff keep saying I'll be back in a minute", "I've been shouting for them and no-one comes", "I sit here all day", "Regular very responsive, agency no" and "staff know their job and carry it out well, they couldn't do anything better than they are". Visitors told us "They need to ask and check not wait for (Relative) to ask, (Relative) can't", "If you can speak up you are OK" and "(Relative) is in bed a lot" and "They know her well".

The provider had a policy for dealing with complaints. We saw that some complaints had been responded to in line with the policy with some evidence that people were satisfied with the responses provided. However, it was not always clear how complaints had been investigated or how learning from them had been taken forward. We saw that a response to one complaint was due to be provided by 12 October however there was no evidence of investigation or response in the file provided. The person that the complaint related to told us they had raised concerns with management but "it dies a death. They say it's being dealt with".

The majority of people spoken with were not aware of how to make a complaint. Comments included "had no information about how to raise a concern – no-one ever said" and "No names given to me so not sure".

This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered person had failed to establish or operate effectively systems or processes to identify, receive, record, handle and respond to complaints.

Each person had a file containing their plan of care. We asked people if they were aware of or had seen their care plans and whether they had been involved in decisions around the care that would be provided. All of the people spoken with told us that they were not aware of their care plan and had not been involved in drawing them up. Comments included "not discussed", "Not asked", "No I haven't, I didn't know I'd got one", "Not seen care plan, not asked for opinion of care plan" and "No we don't".

Care plans followed a task focussed approach and lacked sufficient personalised information about the person's likes/dislikes and preferences, for example "(Name) requires the support of two carers" but no information included about how the person would like their care to be delivered. We noticed that a person's chair faced the window meaning that they could not see their door or staff passing and were heard shouting for help. Staff said the chair was placed that way because the person liked to look out of the window however this was not reflected in their care plan and they were unable to respond when we asked them about it.

Information was difficult to locate within the care files, for example regarding medical diagnoses. We saw that one person had a history of recurrent urine and chest infections however this was not reflected within their care plans nor was the history of chest infections identified on the choking risk assessment although SALT had recommended specialist dietary intake which the person had refused.

Some people told us that they were able to make choices, comments included "I can choose what I want,

when I want" and "Can choose what to eat, who to sit with". We asked about whether people could go to bed and get up when they wanted to. Comments included "No, you have to wait", "You can, but always busy, too busy", "Yes, I can do what I want except if you are going out at 10a.m. we are up at 6a.m." and "We can make choices but have to wait when we do".

A visitor told that that their relative was getting up much later; it had been 11am that morning and occasionally lunchtime. We asked the person what time they liked to get up and they said between 8.30-9am. On another occasion their relative had asked to use toilet at 10.30 a.m. however care staff did not come back until 1.30 p.m. by which time the person had been incontinent of faeces which caused them distress.

Most people did not feel that staff knew their likes and dislikes. Comments included "No I don't think they do", "Not really no, but I try to tell them, "Staff turnover doesn't help this" and "They know (relative) very well", although one person said "They know (relative) very well". We saw that one person's care plan noted they liked tea with two sugars but did not like coffee however the person's visitor told us that their relative did like coffee but a specific brand which they brought in for her. A member of staff told us about an occasion when sweeteners were used in all drinks due to staff not knowing people's preferences.

We also asked if people felt listened to and were told "No, not listened to", "Some do, some don't", "Always listened to but how does it go in" "No I don't think they do" and "No usually saying something on their way out, see the back of them".

A person's drink was put next to them however they were unable to drink independently. Before they were assisted another member of staff said "Come on (Name) you're going to have your hair cut". No choice was offered regarding whether they wanted to visit the hairdresser and the person had not had their drink. When they returned the drink was still there but once again they did not receive support and so did not get their drink.

We undertook a Short Observational Framework for inspection (SOFI), the observation period was thirty five minutes. There were six people seated in the lounge area with no staff present initially. During the observation a kitchen assistant came in, spoke with two people and left again. The registered manager, deputy manager and quality officer entered and sat behind the people seated discussing a person's care plan. Only one of the six people was observed to mobilise during the period of observation.

We were told by care staff that they were not involved in assessment, care planning or review, therefore it was unclear how care staff would be able to gain a good understanding of or changes to individual's preferences and needs, particularly for those who are not able to communicate their wishes.

These issues were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to provide person centred care.

We saw that monitoring charts were not always completed robustly or were not in place. Some care plans noted that positional changes were required to manage the risk of pressure damage. We saw that one person's care plan noted they required two hourly repositioning however there was no positional chart in place and we observed this person in the same position during the inspection.

For others, frequency was confusing as records noted differing intervals. For example, a care plan stated four hourly, but the chart in place three hourly. We asked the nurse about this and were told that the frequency had been changed to 2-3 hourly "for a while" although they felt 4 hourly was appropriate. The care plan had

not been updated to reflect any of this information. The person had a sore on their heel and on their nose caused by their glasses which was covered with a small plaster. The care plan for skin made no mention of either sore.

We identified that one person's personal care had been overlooked on the first morning of inspection. We saw that there were no records made by care staff at the time personal care was delivered in the care file or on a personal care chart. We were told that the CHAPs or nurse in charge would record that care had been given later in the day. We questioned the accuracy of this method of recording as there was no written record of the exact care delivered by staff providing it at the time took place. Staff also told us of two similar instances that had occurred previously.

We saw that fluid charts were used for people who may be at risk of dehydration or infection however found these were not completed properly or were not in place. One person's file noted that staff should "push fluids" but there was no fluid intake chart in place. We asked why this was the case despite the instruction to "push fluids" and were told "We judge whether jugs are empty at the end of the shift". We reviewed other fluid charts and found that these were not sufficiently robust to ensure adequate fluid intake was occurring. This was because staff told us they recorded the amount offered rather than the amount taken, the daily intake was not totalled, there was no indication as to the level of fluid intake that was required or evidence of oversight of these records.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as systems or processes had not been established or operated effectively to ensure compliance with this regulation.

Activities were arranged by two co-ordinators. Both worked similar hours providing activities Monday to Friday between the hours of approximately 9.00a.m. and 15.00p.m. Comments about activities from people living at Cypress Court included "Nothing much, I sit here all day, anything except this", "We just sit here", "We chat amongst ourselves as there is nothing" and "Sometimes there is". Staff told us that although they tried to provide activities when the co-ordinators were not there they were not able to.

A monthly planner was available which detailed the activities taking place such as board games, reminiscence, cheese and wine tasting, outings and one to one sessions. At weekends activities were marked as "available" such as magazines, colouring and books. A hairdresser visited weekly and a church service took place each month.

On the first day of inspection we observed a game of Play Your Cards Right taking place. We saw that this was enjoyed very much by the people and staff taking part with lots of laughter and joining in together.

We became aware that one person had been told they could not attend the church service that day due to a health need. When their relative visited they told us that attending was very important to the person and that they had become upset. We discussed this with the registered manager who identified that there was no risk of infection and arrangements were made for the church service to visit the person in their room. We were concerned that a solution had not been considered before staff made a decision on the person's behalf that they could not attend.

Inadequate

Is the service well-led?

Our findings

We asked people who used the service and their visitors if they thought the service was well-led. Comments included "Basically yes, I think so, doing their best", "It could be better" and "No I don't think it is, swept under the carpet". Whilst some people using services knew who the manager was, some did not. We were told "The manager is always popping into my room", "Yes, there's a man but not sure", "Who is that" and "don't know who the manager is".

We asked staff if the registered manager was approachable and fair. Staff noted a culture of fear saying that they did not report things for "Fear of repercussions" and "There is too much bullying going on. All but one staff member spoken with said that they did not feel listened to by the manager. Comments included "It's a waste of time raising anything, if you speak to the manager it gets out", "Never see her, she should come out more, never acknowledges", and "Doesn't listen, can't talk to her". Staff told us that when they had approached the manager with suggestions or concerns they did not receive feedback and that "nothing changed".

Staff told us that they felt the induction for new starters was insufficient and not managed effectively, feeling that they were included in staffing numbers too soon and that they were "thrown in at the deep end". A recently recruited member of staff told us that they had not yet been shown how to access e-learning and had never met the manager. During the inspection we saw a staff member working on their first day of induction, when asked the registered manager was unable to tell us their name. We also identified that a different member of staff on the first day of their induction had been carrying out manual handling procedures and personal care which they should not have been. The registered manager did not have sufficient oversight of induction and deployment of these staff.

We saw from the matrix provided and staff comments that the registered manager had not carried out supervision and appraisals as required.

Prior to the inspection we were aware that Cheshire East Council (CEC) had been working with the provider following safeguarding incidents earlier in the year. A nominated social worker was appointed to carry out reviews of people using services. We contacted the nominated social worker who advised that they had provided the registered manager with action points from those reviews. We noted that some of the points had not been actioned in a timely manner as some had only been completed following our request for information. One action noted that a person had been without their hearing aids for a considerable time and were now also without their glasses.. There was no reference in the person's care plan for communication regarding the impact of being without those aids.

We contacted CEC quality assurance and contracts team who had carried out a visit to the service in August. They informed us that the provider had not yet received the report from that visit however from the information they provided, they had identified concerns in some of the areas highlighted during this inspection.

We found that the audits carried out by the registered manager were not sufficiently robust or effective.

We reviewed ten records relating to weekly audits of care plans comprising of tick boxes in response to questions. We saw that some of the "No" responses noted that documentation had not been completed properly, for example admission assessment, wishes and choices, progress notes referenced to the relevant care plan. However, there was no indication as to corrective actions needed, the person responsible or confirmation that the issues had been addressed. We spoke with the registered manager about follow up of audits who acknowledged that they needed to do more to ensure effectiveness and said that they did not "want it to become a paper exercise".

A copy of a bed rail check audit carried out 5th monthly identified that risk assessments, consent or best interest was in place for all as needed. During the inspection we identified that documentation was not in place for a person who had bedrails in place however, the audit had noted that this documentation was in place.

We reviewed a monthly medication audit dated 27/8/17 carried out by a resident experience specialist. This failed to identify that there was an expired medication in the fridge for which there was no policy or staff training in place or of gaps in recording of room temperatures.

Another medication quality audit was carried out by the registered manager on 25/09/17. This also failed to identify the expired medication or that PRN protocols were not in place. The audit also did not identify that manufacturer's instructions were not being followed with regard to siting of medicines applied by patch although this formed part of the audit. Regarding whether creams were applied, recorded and stored as policy, the response was marked as "No – currently non-compliant", however this was still the case at the time of the inspection. Only two of the areas of non-compliance noted on the audit were marked as completed.

We saw that a quality audit for nutrition was carried out by the registered manager on 25/08/2017. This indicated that the MUST assessments had been completed correctly for all residents and was reviewed at least monthly, however, we identified that this was not the case.

We looked at handover sheets completed at change of shift and found that these were not always fully completed with date and contained only minimal information. There was no evidence of managerial oversight to ensure that they were being completed effectively.

A fire safety audit carried out in March 2016 resulted in an enforcement notice being issued by Cheshire Fire & Rescue Service under The Regulatory Reform (Fire Safety) Order 2005 for failing to provide general fire precautions to protect both people using services, visitors to the home and staff/. An enforcement notice is a legal requirement for actions to be taken. Four Seasons Health Care were prosecuted and fined for those failings.

Following the inspection we contacted the customer experience regional manager to request a copy of the latest fire risk assessment carried out 13/03/2017. Some areas were identified for attention however, although an action plan was created following receipt of the fire risk assessment, they were unable to find an updated version in the manager's records confirming that the actions required had been completed. They subsequently arranged for the person in charge to review and follow up.

During the inspection the registered manager was not able to demonstrate effective managerial oversight, leadership, understanding of issues within the service or good governance of the service. On several

occasions they were unable to recall the name of people using services, staff members or external professionals. We requested and were provided with a significant amount of documentation, however the registered manager could not produce all the records that were requested and at times did not recall what was asked for even though they had made a written record.

Quality assurance systems were not sufficiently established or sufficiently robust to identify the issues highlighted during this inspection.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014 as systems or processes had not been established or operated effectively to ensure compliance with the regulation.

The registered manager told us that resident/relative and staff meetings were held every three months. We asked for minutes from the last three meetings and saw that staff meetings were held in December 2016, June 2017 and July 2017.

We spoke with people using services and their visitors about attending meetings. Comments included "Not been asked to attend relative meetings, probably because (Name) can speak up", "No meetings held" and "No meetings that I know of". People also told us that they did not feel involved in or consulted about the running of their home.

The registered manager informed us that people could leave feedback using a tablet provided by the service. Despite several requests they did not provide us with any evidence of such feedback.

We saw that there was a process to record accidents and incidents and that the provider had a policy in place to manage such events. Details of accidents/incidents were recorded on a computer system called Datix, which also provided oversight at regional management level. All staff spoken with were able to describe the process to follow with regard to reporting accidents/incidents and were aware of how to access the policy. We reviewed the file containing records relating to accident and incidents which contained printed records along with a hand written index. However, we became aware during the inspection of accidents/incidents for which no record had been created.

We saw that the index was not a contemporaneous record of incidents which had taken place. Records had been filed by date of closure making it difficult to identify themes and trends. Although the manager advised that she was able to oversee trends on the computer system and would print a summary this was not provided despite several requests. This meant that the manager was not able to demonstrate effective oversight of accidents/incidents that had taken place.

We saw that there were eight entries on the summary sheet relating to weight loss or gain relating to six people. However, from records reviewed during inspection we identified significant weight loss had been noted for four other people although there were no entries on the summary relating to these individuals.

We saw that the regional management team had recently reviewed the Datix records on file and had taken steps to address records which had not been closed on the system. Providers have a legal responsibility to notify the CQC about certain events. We saw that the review undertaken had identified that notifications had not always been submitted when required.

These issues were a further breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014 as systems or processes had not been established or operated effectively to

ensure compliance with the regulation.

One member of staff told us that they believed allegations had been made against them because they had raised concerns and that they felt this had not been dealt with appropriately. We were aware that this matter was being dealt with by the provider although an investigation was being carried out it had been delayed due to unforeseen circumstances.

As of April 2015, providers were legally required to display their CQC rating. The ratings are designed to provide people who use services and the public with a clear statement about the quality and safety of the care being provided. The ratings inform the public whether a service is outstanding, good, requires improvement or inadequate. The rating from the previous inspection was clearly displayed within Cypress Court as well as on the Provider's website.

The registered manager and deputy manager both told us that they felt they had been well supported by the provider.

At the time of the inspection the service had a manager who was registered with the CQC in post. They were being supported by members of the regional management team and also by a registered manager from a sister home. During the inspection we saw that members the regional management team were carrying out weekly visits and the registered manager was supported on all three days of the inspection by the customer experience regional manager. The registered manager and customer experience regional manager engaged well with the inspection process responding positively to feedback and reacting promptly to concerns raised throughout the inspection.

Following the inspection we were informed that alternative management arrangements for the day to day running of the home were to be put in place immediately, a robust action plan was submitted and additional regional management support/monitoring would take place to carry out the required improvements. We have since received regular updates from the customer experience regional manager.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person failed to provide person centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person failed to provide care and treatment with consent of the relevant person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person failed to provide safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person failed to establish and operate effectively a system and process to prevent abuse of service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints

Diagnostic and screening procedures Treatment of disease, disorder or injury	The registered person had not established or operated effectively systems and processes to identify, receive, record handle and respond to complaints.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person failed to establish systems and processes to ensure compliance with this regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person failed to ensure that staff had received appropriate training, supervision and appraisal to enable them to carry out the role they were employed to perform.