Bupa Care Homes (GL) Limited

Cleveland House Care Home

Inspection report

2 Cleveland Road
Edgerton
Huddersfield
West Yorkshire
HD1 4PN

Tel: 01484512323

Date of inspection visit:
15 August 2017
22 August 2017
23 August 2017

Date of publication:
03 October 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected Cleveland House on 15, 22 and 23 August 2017. The first two inspection days were unannounced. The last day was announced.

Cleveland House is a care home registered to provide residential and nursing care for up to 45 people over 65 years old. It consists of one building and one purpose built extension with three floors accessed by two passenger lifts. The rooms were all single. At the time of our inspection 36 people were living at Cleveland House.

This inspection was brought forward due to concerns raised by the public and stakeholders.

Cleveland House was last inspected on 4 and 10 January 2017. At that time the service was rated requires improvement and had two continuous breaches of regulation relating to safe care and treatment and good governance which had already been identified during our previous two inspections. Following the last inspection, we asked the provider to take action to make improvements to their processes in relation to risk assessments, medicines and auditing. At this inspection we found the service had not made enough improvements and was still in breach.

The home did not have a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (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. There was a home manager in post but they had not yet registered with CQC.

Although efforts had been made to register a manager and an application had been sent to CQC this was subsequently returned due to incompleteness and a new one had not been submitted. The registered provider had failed to comply with a condition we had applied to their registration requiring them to appoint a registered manager.

Risks associated with people's individual care needs were not always identified or managed appropriately. Medicines were not administered safely at the home and people had been put at risk of harm. During our inspection we raised safeguarding concerns in relation to medication.

Staffing levels were not always sufficient to ensure people received the care they needed. Staff had not always been recruited safely to ensure they were suitable to work at the service. Staff had completed relevant training however, we found examples where staff's knowledge was not effective in meeting people's needs. Staff had supervision but not as regularly as stated in the registered provider's own policies.

People's mental capacity was not always assessed and best interest decisions were not always completed in line with legislation.

People's nutritional and hydration needs were not being appropriately met and the registered provider was not managing people's weight loss safely.

People did not always receive dignified care in accordance with their preferences. The registered provider was not consistently involving people and their relatives in making relevant decisions about their care.

People's personal information was not always stored securely.

People were offered social stimulation on a regular basis through varied and meaningful activities.

There were care plans in place; however, the quality of these care plans fluctuated and some contained contradictory information which put people at risk of inappropriate care.

The registered provider did not have a robust approach to dealing with complaints and people and their relatives could not be reassured their concerns would always be valued and acted upon.

Staff's morale was low and there were substantial issues with the home's organisational culture due to lack of strong leadership.

The systems of governance in place and the home manager's oversight were not robust to implement changes and this was having a negative impact on the overall quality of the service.

The registered provider was in continuing breach of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

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 vary or 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 or 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. 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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people's safety were not always well managed. Staff did not always have the appropriate guidance to support people safely.

The management of medicines was not safe.

Accidents and incidents had been recorded but further analysis was required to keep people safe and to reduce the risk of further events.

There was not always enough staff on duty to meet people's needs and staff were not always recruited safely.

Is the service effective?

Inadequate

The service was not effective.

The home was not fully compliant with the Mental Capacity Act 2005.

People's nutritional and hydration need were not always managed effectively.

Staff had received some training, supervision and appraisals to support them in their role but this was not always up to date and in line with the registered provider's policies.

Is the service caring?

Requires Improvement

The service was not always caring.

People did not always receive dignified care in accordance with their preferences.

People's personal information was not always stored securely.

People could not be reassured their end of life wishes would always be considered and acted upon by the registered provider.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care was not personalised to ensure consistent care was being provided. Although care plans were regularly reviewed the information was not always updated to reflect people's current needs.

There was a meaningful activities programme to ensure people were able to maintain their hobbies and interests.

Complaints were not always managed in a robust way.

Is the service well-led?

Inadequate

The service was not well-led.

Staff reported low morale and there was a lack of effective leadership.

The registered provider had not taken appropriate action to ensure the service was compliant with the regulations.

The systems for monitoring and checking the quality of care provided were not effective.

Records were not always accurate or up to date.

Cleveland House 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.

We inspected Cleveland House on 15, 22 and 23 August 2017. The first two inspection days were unannounced. The last day was announced because we wanted to make sure the home manager would be available to receive the inspection's feedback. The inspection team consisted of three adult social care inspectors, a pharmacist and an expert by experience on the first day and two adult social care inspectors on the second and third days. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience who was part of this inspection had experience caring for older people and people living with dementia.

Before the inspection, the provider completed a Provider Information Return (PIR). This 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 also reviewed the information we held about the service. This included correspondence we had received and notifications submitted by the service. A notification must be sent to the Care Quality Commission with the details of certain incidents, events and changes that affect a service, or the people using it.

We also contacted local stakeholders to have their views on the care provided at Cleveland House. These included the local authority safeguarding team and commissioning team, the Clinical Commissioning Group and Healthwatch Kirklees. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. Some stakeholders shared information of concern that helped us plan for our inspection.

During the inspection we spent time observing care in the communal lounges and dining room, we spoke with nine people living at Cleveland House and five relatives or friends. We also spoke with 12 members of care staff including the home manager, regional support manager, regional service recovery director, care manager, clinical lead nurse, two nursing staff, one senior care staff, two care staff, one catering and one maintenance staff. As part of our inspection we looked at four care plans in detail and sampled some areas of other care plans. We looked at ten medication records. We reviewed three staff records and other records which related to the management of the home, including policies and procedures, fire checks, audits and minutes of staff and resident's meetings. We also spoke with two visiting healthcare professionals.

After our inspection, we asked the registered provider to send us additional information including information that had not been made available during our inspection, information in relation to concerns identified during inspection and actions taken to address those concerns. The registered provider sent us some but not all the information required within the agreed timescales.

Inadequate

Is the service safe?

Our findings

At our last inspection on 4 and 10 January 2017 we found the registered provider was not meeting the regulations in relation to providing safe care and treatment as risk assessments and medicines were not always managed appropriately. This was a continuous breach from our previous inspection on 4 and 11 May 2016 where the service was rated as inadequate in this domain. At this inspection we found the service had not made sustainable improvements and had deteriorated to the level of quality and safety found in May 2016.

People shared with us mixed views about their feeling of safety at the home. One person said, "They are very easy going, they don't bully you." Another person said, "They are very security conscious, it's a bit difficult at times." And another person said, "Some of the new staff [clarified as agency staff] don't speak English and can't understand you. I worry what would happen if I was ill?" We asked one member of staff if people were safe. They told us, "I don't personally think so."

At our last inspection on 4 and 10 January 2017 we found risks to people were not always managed safely as moving and handling risk assessments lacked detail in relation to specific equipment and techniques to be used. At this inspection we found this was still happening and we identified new issues relating to the lack of risk assessments and managing the risks to people to keep them safe.

The service used a moving and handling risk assessment and care plan to identify and promote the safe handling of people at the service. However, we found the information in the risk assessment and the care plan lacked detail. For example, one person's manual handling risk assessment indicated they needed to be supported with transfers by use of a hoist however, there was no indication of the risks that had been assessed, which type/model of hoist to be used or the method staff were required to follow to safely move people. Another person who also required a hoist to be safely moved had a moving and handling risk assessment but no corresponding care plan. During our first inspection day, we looked at one person's care records and saw they were taking medicines to control their epilepsy; however, there was no risk assessment or care plan for this condition and staff we spoke with were unfamiliar with how they should respond in the event of a seizure.

The registered provider used standardised risk assessments such as the Waterlow scale, which is a tool to assist staff to assess the risk of a person developing a pressure ulcer and 'MUST' (Malnutrition Universal Screening Tool) which is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition however, these risk assessments were not always accompanied by the necessary care plans. One person had been assessed as having a very high Waterlow score which meant they were at high risk. Their body maps indicated they had lesions and wounds in different areas of their body; however, the wound care plan that did not detail how staff were required to manage this condition. This meant people could not be reassured staff had access to appropriate and up to date information to support them in a safe way.

We inspected the care records for one person who was known to be at risk of falls. Their risk assessment

indicated this person had a "tendency for risky walking" which included getting up and walking unassisted. When we looked at this person's falls records we saw they had had four falls between January and August 2017 and on two of those occasions had broken their hip. We saw this person's care records indicated that during this period the preventative measures remained the same. We spoke with the home manager about how this person's risk of falls had been managed and they told us staff kept this person under close supervision. However, there was no indication in the care plan or recording in daily notes of how often this person was checked during the day.

These examples demonstrate people's risks had not been identified or managed properly; which demonstrated the registered provider was in continuous breach of Regulation 12 (2) (a), (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment.

At a previous inspection in 4 and 10 January 2017, we identified the home to be in breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 because medicines were not managed safely. At this inspection, we found that appropriate arrangements for the safe handling of medicines were still not in place and people were being put at risk.

We asked people if they felt they received their medication on time, comments included: "They bring my medication every day" and "I get my medicine on time."

We found fridge and room temperatures had not been recorded daily in July and August 2017 and where the temperatures had exceeded the maximum recommended range actions had not been taken. Not recording or taking action to abnormal temperature results is not in line with national guidance or the home's policy and increases the risk of medicines not working effectively. Controlled drugs (medicines which require additional checks due to their potential for abuse) were stored securely and the key held by the nurse on duty.

The majority of medication administration records (MAR) were printed by the community pharmacy. Where handwritten entries were made, two nurses did not always sign them, which is not a safe practice in line with national guidance as it increases the risk of a transcribing error which could lead to an incorrect dose of medicine being administered.

We checked the processes in place for ordering of medicines. We found one person's medicines had been recorded as 'cannot find/out of stock' for two days, However, we found these medicines were located in the medication trolley. We brought this to the attention of staff during the inspection. In addition, this person required daily recording of their pulse, this was to be recorded at the same time as the medicines were administered however, on the two days where the medicines had not been given the person's pulse had also not been recorded. A further two people required medicines to prevent urinary tract infections. These medicines were listed as out of stock for four days in August 2017. We were told the medicines could not be supplied by the routine pharmacy and it had taken four days to source them from a different pharmacy. Registered provider had failed to ensure there were sufficient quantities of people's medicines to prevent the risks associated with medicines that are not administered as prescribed. This is a breach of Regulation 12 (2) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found medicines were not always given in line with the prescribed instructions. One person was prescribed a medicine to aid digestion of food with the instructions 'to be taken with food' however; we observed this medicine was not given with meals. On the 15 August 2017 we observed the medicines round for one part of the home did not finish until 11.40am. One person who was prescribed medicine for their epilepsy, to be given at 8am and 8pm did not receive their morning dose until 9.45 am which increased the

risk of them having a seizure. The lunchtime medicines round for one unit did not start until 2.50pm and one person who took medicines for Parkinson's prescribed at lunchtime received their dose between 2.50pm and 3.30pm; not taking this medication on time can contribute to a decline in the person's health, for example, increase of involuntary movements or decline in mobility. A third person at the home had not received their medicines in a timely manner; this meant the person had not received the correct daily dosage of their medicines for four days increasing the risk of worsening the condition for this person. This meant people were being put at risk of harm due to inappropriate management of medicines. We shared our findings with the home manager and as some of the concerns raised with the mismanagement of medication could cause harm to people these required immediate reporting to the local safeguarding team. The day after our first inspection day we were informed by the regional support manager these referrals had been made to the appropriate team and the registered provider also submitted the required notifications to the CQC.

We observed that when 'as required' medicines where given these were not always recorded on the back of the MAR as per the home's policy. This meant staff were unaware why they had been administered and therefore, if they had been effective. Two residents did not have when 'as and when required' protocols in their MAR folder to guide staff how and when to administer these medicines.

During the inspection we observed one person who was visibly in pain. PRN medicines had been administered to this person early in the morning and additional medicines had been given during the morning medicines round to relieve pain with no effect. We observed the nurse on duty recognised the person was not responding to their pain relieving medicines but did not act to administer more medicines after a suitable time period or called for additional help. We intervened and the nurse administered additional pain medicines as an appropriate time period had lapsed; an ambulance was called and the person was transferred to hospital. We asked the home manager if this nurse's medication competency was up to date; the home manager told us they were however, they could not show us evidence of this during the second or third inspection days. We asked for evidences of medication administration competencies for another two members of staff and we found one was in date but the other staff member had only been partially completed. This meant the registered provider could not evidence that staff administering medication had the necessary and up to date competencies, knowledge and skills.

This demonstrated a breach in Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked to look at medication audits carried out in the previous three months. Audits for May 2017 were provided; audits for June 2017 and July 2017 could not be supplied during the first inspection visit but were emailed by a senior manager the following day. The audits showed the home did not fully comply with their own policies for example, in both June and July's 2017 fridge temperatures had not been recorded as required and records of topical creams had not been checked. Although action plans were in place and these had been signed as completed, issues found in June's 2017 audit were mirrored in July's 2017 audits and we continued to find the same concerns in our inspection in August 2017. This meant learning from audits and subsequent actions were not taking place and improvements were not being made.

The lack of robust audits to identify and implement improvements in the management of medicines demonstrated a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff and the home manager were able to identify the main types of abuse and what to do if abuse was recognised. We spoke with staff who told us they would not hesitate in reporting any concerns to their line

manager. This showed there were safeguarding procedures in place to protect people from abuse and neglect. However, due to the concerns found during our inspection and information shared with us by other professionals we concluded the procedures in place were not always effective to protect people from harm.

We looked at how accidents and incidents were being managed by the home and we found these were being recorded and the care manager was auditing these monthly however, their analysis was not robust as did not identify actions needed to address concerns, and any trends or measures to be put in place to prevent future incidents.

We checked how the service ensured there were sufficient numbers of staff to keep people safe and meet their needs and we found this was an area of concern for people living at the home and staff. One person told us, "I just push my buzzer if I need anything; if I ring twice they know it's important and come straight away." Another person said, "They are short staffed, you can wait 10 to 30 minutes for someone to come if you need the toilet." Another person commented, "They are short staffed, they say 'we will be back in a couple of minutes' but it can be half an hour. I do it on the toilet floor sometimes then. They are very kind they just say, 'Don't worry about it." And another person said, "They don't have enough staff, sometimes I don't get turned when I should."

When we asked staff about the home's staffing levels, their concerns mirrored the ones raised by people. One staff member said, "It's not good enough, it's a big home. I think we need a minimum of eight carers in the morning." We asked this particular staff member if they had shared their concerns with the management of the home and they confirmed they had but "nothing had happened". We asked another staff member whether the service was always fully staffed. They commented, "The majority of the time lately, we haven't been."

We asked staff what was the impact of low staffing levels and they told us people were rushed or their needs were not met; there was no time to chat with people and care was not always documented. One staff member said, "They've had four people complaining this morning they're wet." A second staff member said, "Sometimes you get rushed and then you forget to make them a cup of tea." And a third staff member added, "If you're under pressure, you'll think, 'I'll fill it in (care records) later' and then it gets forgotten." This meant the home did not have the necessary number of staff to ensure people's needs were met and necessary records of people's care kept up to date.

We asked the home manager and regional support manager how staffing levels were calculated. They told us a dependency tool was used to calculate people's needs on admission and reviewed when needed. The home manager told us the home was currently operating with staffing levels over their calculations to allow for staffing fluctuations and due to the layout of the building. However, when we analysed the rotas from previous weeks we found this was not happening and the home was consistently working below their staffing calculations. For example, we saw in a period of 28 days, the nurse's shifts were understaffed for 10 days. The same was happening with the care staff shifts; we saw in a 14 day period, 10 shifts were understaffed. We observed this trend was also happening in relation to covering night shifts. We shared this information with the home manager and they told us they did not feel this was a concern as when there were staff shortages they redeployed staff that usually did not have caring tasks. The home manager also said they used agency staff at times. We asked for the days and times agency staff had been used in July and August 2017 to ascertain if this matched the gaps we had previously identified, however, this was not provided by the home manager during inspection.

We also inspected the call bell times; this registers when people press their buzzer to call for staff and how long they had to wait for staff to respond. The home had a policy of responding to call bells within eight

minutes; however, we observed this was not always happening. For example, we saw between the 13 August 2017 and 15 August 2017 there were instances where people waited 11, 12, 32 or even 41 minutes for their call to be responded. These instances were also noted by the regional support manager during our first inspection day, who commented, "They need to do some work on their response times." We were informed the care manager had the responsibility to audit the call bell times; so we discussed our concerns in relation to those days with them. They told us they spoke with staff and staff said "They were dealing with someone else" therefore other people requesting assistance had to wait and no further action was taken. This showed the care manager was not effectively managing the issues caused by low staffing levels.

This evidence demonstrates a breach in Regulation 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the home was not able to provide and deploy enough numbers of suitably qualified staff to meet the needs of people.

Staff were not always recruited safely. Full recruitment checks should be carried out before staff start work to ensure there is no known reason they should not be working with vulnerable people. When we looked at the records of one staff member we found their employment history only indicated years and not months and the information did not match the curriculum vitae on file therefore, we could not be certain if employment gaps had been investigated as required. This same staff member's references were not dated. Another staff member's recruitment records showed gaps in employment and again there were no evidence this had been investigated. We discussed this with the home manager during our first day of inspection and they told us they would be in contact with their recruitment team to address concerns.

Records of weekly fire alarm tests and testing of call points were seen. We saw the fire procedure was on display in different parts of the home. Equipment used in the event of a fire had been recently checked to ensure this was in working order. We looked at the fire register and saw people's needs had been rated using a red, amber and green system. However, the key recorded needs such as red referred to 'non ambulant, full assistance required' meant it was not clear what kind of moving and handling equipment was needed in such an emergency and the number of staff needed to assist the person was not recorded. It is important to ensure people can be evacuated swiftly and safely in the event of an emergency. We asked staff about the home's evacuation procedures and how they would support people and some staff were not clear of what they should do. We shared our concerns with the management of the home and we were told appropriate action would be taken.

During our inspection we looked at maintenance records and saw evidence of certificates for electrical wiring and gas safety which were found to be up-to-date. However, the certificate for lifting equipment, for example, hoists and slings expired on the first day of our inspection which meant the service would not have been compliant with Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). We were shown by a member of staff these checks had been planned for over a week later. At our second inspection day we were shown evidences that the LOLER testing had taken place.

We saw evidence of routine maintenance which was carried out promptly. Portable appliance testing had been carried out in February 2017 and window restrictors were in place to reduce the risk of falls from a height. Hot water temperatures were checked to ensure this was safe and monthly legionella checks were carried out. This meant the registered provider was taking actions to ensure the suitability and safety of the premises.

Inadequate

Is the service effective?

Our findings

At our last inspection on 4 and 10 January 2017 we found the registered provider's ability to provide effective care required improvement. At our previous inspection on 4 and 11 May 2016 the service had been rated as inadequate in this domain. At this inspection we found the service had not sustained improvements and had deteriorated to a similar level of quality found in May 2016.

During the inspection we gathered mixed information about the quality of people's meal experience at Cleveland House. People told us the food was good and there was plenty to eat. Comments included, "The food is very good; it's cooked here in the kitchen", "The food is excellent you get a good choice", "I can eat in the dining room or in my chair in the lounge" and "I eat in my room, it's always hot when I get it and I get the same choice as the dining room." However we also gathered information of concern about the way the home was managing some people's nutritional and hydration needs.

We saw the dining room was set nicely with cutlery, napkins and menus. The menu had two choices of main meal at lunch and evening meal with a choice of dessert. There was an alternative menu and also a "night bite" menu. During breakfast we observed people chatting and care staff offering people a choice of meal. We saw records of people's dietary needs in both care plans and the kitchen area and a kitchen staff member we spoke with was able to describe how they fortified meals and ensured people's dietary requirements were supported where they had diet controlled diabetes or needed soft or pureed foods. We saw one person who required a gluten free diet had specialist ingredients purchased for them.

However, during our inspection we noted some instances were people's nutritional needs were not being appropriately met. For example, one person who had been assessed as being nutritionally at risk, had been prescribed supplements to increase their weight; these had not been ordered by the home and the person did not take them for two consecutive months. Another person had lost 4kg between January 2017 and July 2017 but their food intake was not being appropriately monitored as daily notes only indicated if the person had a "good" or "small diet" which did not enable staff to accurately know how much the person had eaten. We spoke with staff who told us this person had been declining food and they had tried to encourage them to eat and drink more; however, this could not be evidenced as the last week's daily records could not be located. We spoke with the lead nurse about this person's nutritional needs and they were not aware this person required close food monitoring due to weight loss but agreed it would have been appropriate for this person to have been placed on regular food charts. This meant the registered provider was not managing systems effectively to identify record and appropriately act on concerns related to people at risk from inadequate nutrition.

We looked to see how people were being supported with their fluid intake. We identified areas of concern to indicate people's needs were being appropriately met. One person's care plan indicated they needed thickener added to their drinks to prevent the risk of choking. When we looked at this person's daily records we noted they had been given the double amount of thickener that had been prescribed. We shared this information with the lead nurse and they did not know why this was happening and reassured us they would take immediate action. According to information published by the NHS, increased quantities of thickener in

drinks can reduce the bioavailability of other medications therefore, it is important appropriate amount of thickener is prescribed and given. We checked the records for another person who was prescribed thickeners and we saw several gaps in recording; therefore, we could not be certain this person had been supported with regular fluid intake with the appropriate amount of thickener. We were informed by a third party that one person who had lived at Cleveland House had not been suitably hydrated which caused them harm. We spoke with the home manager and the senior management about these concerns and they told us they had reviewed the home's thickener protocols and had designated a staff member to review the entries made and ensure correct reporting.

We looked at how people's weight loss was managed and we found action was not always taken in a timely manner to promote people's health and wellbeing. We asked the lead nurse and home manager about their procedure to manage people's weight loss. They told us if people lost more than 2kgs in a month, they would be placed on regular food charts, weighed regularly, encouraged with food intake and if no improvement was noted a referral to the GP or dietician would be done. We asked for the home's policy in relation to weight loss but this was not provided.

We saw evidence of recording and auditing being done in regards to people's weight loss, however, after looking at people's care records we concluded the home was not managing this area of people's care effectively. For example, one person was on a fortified diet and their eating and drinking care plan had been reviewed monthly. Weight records showed this person had lost 2.5kg between June and July 2017; their daily records in July 2017 indicated this person was having 'poor food intake' but there was no indication what action had been taken to support this person and seek appropriate advice. A second person had lost 5kg between June and July 2017 and no action had been taken. A third person required their weight to be monitored weekly however, they had been weighed monthly and records showed that between January and August 2017 they had lost 10kg. Although a referral to the dietician had been made, records from two healthcare professionals stated, 'Weight reduced further as lost 2kg since 15/05/2017 and underweight. No food chart kept, so unable to assess properly, despite asking the home to keep one'' and 'Tried to assess but no food charts kept so unable to. Plan – speak to manager about this issue'.

This meant people's weight loss was not being appropriately managed by the home and people's health was being put at risk. We discussed our concerns with the home manager and senior management and they told us they would take action to address these concerns. However, when they described these actions we found they did not substantially change what the home was already doing. This meant we could not be confident the registered provider's management of people's weigh loss was effective to keep people safe.

During our inspection we confirmed people were having access to healthcare professionals but as evidenced above people's health care needs were not always managed in a way to ensure they received specialist support in a timely way from healthcare professionals. This meant people had some access to healthcare professionals when needed, however, referrals were not always done timely to ensure people were receiving the professional advice they needed. Records showed doctors had attended the service and during one of our inspection visits we spoke with a visiting GP who told us they had no concerns regarding medical assistance been unnecessarily delayed by staff and they felt staff were responsive to people's needs "Most of the time."

The demonstrates the registered provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in particular Regulation 14 because people's nutritional and hydration needs were not being met and Regulation 17 because of a lack of good governance in assessing, monitoring and mitigating risks to people's health and welfare.

We checked and found that people's consent wasn't always being sought in line with legislation and guidance.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We asked staff about their understanding of the MCA and the impact it had on the care they delivered. Staff told us about some of the decisions people needed support with and explained how this support was offered by giving people choices and alternatives.

When we looked at people's care plans we found some assessments of mental capacity had contradictory information, best interest decisions were not always recorded and relatives were signing consent forms without the legal authority to do so. For example, one person's pre assessment information stated they had variable capacity due to living with dementia. This person's mental capacity assessment to decide to live at the home was blank as well as its correspondent best interest decision and there was a consent form in relation to access information signed by a relative without lasting power of attorney (LPA). An LPA is a legal document that allows someone to make decisions for you, or act on your behalf, if you are no longer able to or if you no longer want to make your own decisions. LPA's can be put in place for property and finance or health and welfare decisions. We asked the home manager if they had evidence of relatives having LPA; they said these should be in people's care plans; however, the home manager did not show us any copies of LPA and we could not find any copies in care files sampled during inspection. This meant the registered provider was asking family members to sign consent forms when they did not have the legal authority to do so.

During our inspection, we saw the mental capacity assessment for one person was not decision specific; the decision requiring assessment was stated as "variable capacity" and the outcome of this assessment had not been recorded. This was not in line with legislation and good practice and did not provide any relevant information to staff supporting this person. One person's care plan recorded they could make simple, 'Yes' or 'No' decisions; we saw a mental capacity assessment and best interest decision for a flu injection had been signed by the clinical services manager and there was no evidence of the involvement of family or an external health professional, such as a GP. This meant people who lacked capacity to make decisions about their care could not be reassured these would be made following the best interests process and consent sought by those with the legal authority to do so.

This evidence demonstrates a breach in Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty so they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our inspection, there was one person living in the home who had a DoLS authorisation in place and applications had been submitted to in relation to another five people.

During this inspection, we asked people if they felt their rights were being restricted in any way by staff and if they could make choices about everyday decisions. People's feedback was consistent, they felt they could

made decisions and these were respected by staff and our observations during inspection confirmed this. One person told us, "I go to bed about nine but I can stay in the TV lounge all night if I want."

We asked people if they felt staff had the skills and training to perform in their role, people responded affirmatively. When we spoke with staff and inspected people's care records, there was variability to how knowledgeable staff were about people's care and support needs.

One staff member was able to tell about a person's health condition, their communication and mobility needs. Another staff member told us about a person's preference for listening to music. We found instances of staff not being well informed about people's needs. For example, the clinical lead nurse and care manager were not aware one person was on food and fluid charts due to risks with nutrition and weight loss. One staff member was not aware one person had a diagnosis of epilepsy and did not know the care this person may require with this medical condition. We saw the records made by a visiting professional stated, "[Person] aspirated today on watery custard that should have been thickened. Informed catering of this and manager. Catering needs to communicate with carers over responsibility of thickening fluids as carers not aware at present which is a risk to dysphagic patients." This meant people could not be reassured they were always being supported by staff who had an effective knowledge about their needs and would support them appropriately.

We looked at staff's induction and training and we saw evidences of this being completed however, not all staff training was up to date. Training the registered provider highlighted as essential included manual handling, infection control, safeguarding, fire safety and dementia. Staff told us they had also received training in subjects such as using catheters and diabetes awareness. We spoke with the home manager and senior manager about some staff's training being overdue and they told us they were addressing this matter with their training team.

Staff we spoke with told us they received quarterly supervisions as well as an annual appraisal. The home manager told us they aimed to complete supervision every three months however, when we looked at the supervision records we saw this was not always happening and most staff had had a five to six month interval between supervisions. Staff told us they were able to add to their own comments to their supervision records which demonstrated this was a two way conversation. One staff member who we asked about supervision said, "Generally, they're good. They do tell you where you've improved." This meant staff had some support to perform in their roles and maintain their skills however; this was not as regular the registered provider's own policies' required.

Requires Improvement

Is the service caring?

Our findings

At our last inspection on 4 and 10 January 2017 the registered provider was rated good in providing a caring service. At our previous inspection on 4 and 11 May 2016 the service had been rated as requires improvement because person centred care was not always provided in line with regulations. At this inspection, we concluded the registered provider was not able to sustain the improvements seen at last inspection and required improvement.

People reported the care staff were kind. Comments included: "I'm very happy here, the girls are very good", "They were very kind and sympathetic when I came in, they would sit and talk to me and held my hand a couple of times", "They are very understanding, very helpful" and, "The young girls here are a credit to today's youth; they are polite and respectful." One relative told us, "Overall, I'm very pleased with the care my [relative] received. I'd give them nine out of ten." One staff member we spoke with told us, "I love working here."

We observed a mixed quality of care in the interactions we saw between staff and people. For example, we observed a member of staff who helped a person who was wearing glasses which were not fitted straight. They explained what they were doing to the person and straightened them which helped the person maintain their dignity. A staff member helped two people to engage in a game of dominoes which they both enjoyed. There was good humour with one person commenting about the staff member, "I've taught her too well."

We saw staff assisting people in to a lounge area. One person was left with a nurse call buzzer and the staff member told them, "If you need me, just press the orange button." However, another person in the same lounge was left with their drink and buzzer in a place they could not reach. When they wanted assistance, we saw them hitting their hand against the armchair they were sitting in. At 10:45am, one person asked staff for a cup of tea which never arrived; they later asked for a cup of tea again at 12:18pm which arrived at 12:25pm. We asked the staff member why it had taken so long to provide a drink to this person and they said they had been unable to find the thickener which needed to be added to drinks for this person.

During our inspection, we considered if people's privacy and dignity was being respected at Cleveland House.

Staff could describe how they respected people's privacy while providing care. One staff member told us, "I've never walked past and seen doors open when people are getting changed." However, during our inspection visits we observed instances were people's dignity had not always been respected. For example, we observed two members of staff assisting a person from their wheelchair to armchair; as they were hoisted, the blouse the person was wearing was raised exposing part of the person's bottom. We saw one staff member make an effort to cover the person as another person asked where their cup of tea was. The staff member began talking to them across the lounge, which meant the person was left in the hoist for longer than they needed to be. We also observed bedroom's doors left open when people were in bed or where not there. When we checked these people's care plans we saw records did not evidence people's

preferences and ability to make the decision to leave door open had been appropriately sought. One person had been assessed as lacking the capacity to consent to care; their safety care plan stated, "[Person] likes her bedroom door opened when [person] is in the room", however, there was no specific mental capacity assessment and best interest decision in relation to this particular aspect of care. Another person's care plan stated they lacked the capacity to make decisions in relation to 'care planning' but their safety care plan indicated, "[Person] would like door left open when not in [person's] room. [Person] is aware of the risks." This meant people could not always be reassured staff would support them in a way that would be dignified according with their preferences or best interests.

During our inspection, we saw people's files with confidential and sensitive information were not stored securely as they were often left unattended outside of their rooms. This meant people could not be reassured their private information would not be accessed by individuals without the permission to do so. We raised our concerns to the home manager who advised us they would take appropriate action.

This demonstrates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked if people and their relatives were being involved in planning and reviewing their care and we received mixed views. There was evidence care plans were regularly reviewed however; these reviews were generally only conducted by staff. We spoke with one relative who told us they had requested staff to support their relative, who had difficulties communicating, not to be left alone and to be sat where other people were having conversations. This relative then added, "I never know which room [person] is going to be in when I come. They have listened to me and do that all the time." Another relative told us they did not feel sufficiently involved, even though they had a LPA. Their comments included, "I know there was a care plan but I was not involved in any care plan conversation. There should have been some sort of induction when we first came here. I have power of attorney and it was known by the management." This meant the registered provider was not consistently involving people and their relatives in making relevant decisions about their care.

We asked staff how they would support people at the end of their lives; one staff member told us about the importance of "Making people comfortable, pain free and a settled death." When we looked at people's care plans we saw some people had a future decisions care plan however, we saw two care plans which had mostly been left blank. We also identified several "Do Not Attempt Cardiopulmonary Resuscitation" (DNACPR) forms that were invalid and could not be used if required. We shared our findings with the home manager and they said they would take appropriate action. This meant people could not be reassured their end of life wishes would always be considered and acted upon by the home.

During this inspection we considered if people were being supported to maintain their independence and we concluded this was happening. One resident said, "They have me walking up and down to keep me going." One relative shared with us, "[Person] is 100% better than when [person] came in." One staff member commented, "I do try to give them as much independence as possible." We observed one person being supported by a staff member to get up and mobilise in a way that reinforced their independence and autonomy.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 4 and 10 January 2017 the registered provider was rated good in providing a responsive service. At our previous inspection on 4 and 11 May 2016 the service had been rated inadequate in this domain. At this inspection, we concluded the registered provider had not been able to sustain the improvements seen at last inspection.

We checked to see how the registered provider was acting on complaints. One relative told us they had raised concerns in relation to staff leaving drinks for their relative which presented a choking risk as they had aspirational pneumonia. We spoke with the care manager and they confirmed this had happened once and was reported to the safeguarding team. During one of our visits, we observed one person complaining of severe pain and not being provided with pain killers or access to medical advice in a timely way. This person's visiting relative told us they had raised their concerns to staff several times until medical assistance was sought and this relative added, "If I hadn't been here I don't think anything would have happened." There was a complaints procedure in place and we saw complaints were recorded in a file. There was a board in the foyer informing people how to complain. Since our last inspection the home had received nine complaints and there were evidence of these being acted upon and responded. Two people and one relative told us they had submitted a complaint and this had been responded to their satisfaction. This showed the registered provider did not always have a robust approach on dealing with complaints and people and their relatives could not be reassured their concerns would always be valued and acted upon.

The home manager told us they assessed people prior to admission to the home. The pre-assessment included gathering information about people's needs and preferences, for example; eating and drinking, personal hygiene, skin integrity, senses and communication, cultural/spiritual/religious practices and relationships/community involvement. The home manager told us during this pre-assessment stage, people's care needs were categorised in different bandings that informed the dependency tool used to calculate the staffing levels required at the home. This meant the service was assessing people's needs and the service's capacity to meet those needs before taking on new residents, with the view of providing individualised and sustainable care.

When we looked at people's care plans, we saw these had a standard organisation which included a summary of people's needs, called 'my day, my life, my portrait', followed by the pre-assessment, records of professional visits and referrals, daily notes and specific risk assessments and care plans such as choices and communication, lifestyle, safety, moving around, skin care, washing and dressing, going to the toilet, eating and drinking, breathing and circulation, mental health and future decisions. However, we found the quality of the care plans we reviewed fluctuated and some had contradictory information.

One person's communication care plan stated they 'like to chat with people but choose when and whom to talk to' but their health care plan stated this person was 'unable to verbally communicate needs'. This same person's health care plan indicated inconsistent information about how often they could take PRN medication; some records indicated they could have paracetamol twice a day, others four times a day. We shared our concerns with the lead clinical nurse but no actions were required as the home was no longer

providing care for this person. We looked at one person's care plan and found there was no life history. Another person had been admitted to the home on the 20 June 2017 but on the first day of our inspection they did not have care plans in relation to washing and dressing, oral care, manual handling, going to the toilet and future decisions. This meant staff did not always have access to relevant and up to date information in relation to people's needs and preferences.

This demonstrates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as accurate and contemporaneous records were not always kept.

During our inspection we saw people were offered choice. We heard one staff member ask, "[Name of person] which room would you like to go in?" We also observed people being asked where they would like to sit. One person told us, "I can stay in bed if I want. I like to stay in bed until 11am."

In response to the last satisfaction survey, people and relatives requested a varied activity programme to be put in place. The registered provider responded, "We have recently employed a new activity coordinator, [name of coordinator], who will be providing an extensive and varied activity programme." One staff member said, "Since [activities coordinator] has come into post, it's so much better." We were told by staff that singers regularly visited the home and trips out to the park and to a local café as well as a boat trip had taken place. We looked at the recording of activities which people had participated in and found detailed records of when people had engaged with activities, what they had done, and notes regarding the person's level of participation and enjoyment. There were records of when people had preferred not to join in with activities. People commented, "I have been to the art gallery; I had not been for years; some of the staff took me", "The [activity coordinator] who does the activities try's allsorts, I did an I.Q. quiz with her and I went to the beach party." The evidence we saw showed people were offered social stimulation on a regular basis. Activity records also demonstrated that people who stayed in their rooms, either by choice or due to ill health were also given an opportunity to participate in activities.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 4 and 10 January 2017 we found the registered provider was not meeting the regulations in relation to good governance as the manager in post was not registered with CQC, the auditing processes were not effective in making sure improvements were made and there were areas where the service required improvement. This was a continuous breach from our previous inspection on 4 and 11 May 2016 where the service was rated as inadequate in this domain. At this inspection we found the service had not made enough improvements and had deteriorated to the level of quality found in May 2016.

We asked people and relatives if they knew who the home manager was and if they could speak with them, comments included, "The manager is good, listens to what I have to say" and "I see [home manager] knocking around."

We asked staff's views about the home manager. One staff member told us, "I sometimes feel supported by [home manager]." Another staff member said, "[Home manager] is on call at weekends. You won't ever see [home manager] come in. Sometimes, I feel [home manager]'s not on our side." Another staff member commented, "You barely see [home manager]. [Home manager] does spend a lot of time in the office. The manager does not support you." And another said, "I am so overworked I can't do my job. They (carers) have been in tears."
Our observations during inspection concluded staff's morale was low and there was a poor organisational culture at the home due to lack of effective leadership. A strong organisational culture has a positive impact on staff wellbeing, attitudes and behaviours and generates high quality performance to the recipients of a service. When we looked at staff meetings minutes we found these were taking place on average every month and issues with organisational culture were evident. For example, minutes from one meeting recorded, "Cleaning mattresses – please stop saying it's not your job; let's make it our job and work as a team at Cleveland House", "Open floor – raised concerns about not working as a team and staff going for breaks before everything is done" and "The importance of completing care for our residents was raised as often it was felt that hair and nails and bathing was somebody else's job; it is all our responsibility to ensure all our residents are treated with the utmost respect and dignity." We spoke with the home manager, clinical lead nurse and care manager about our findings in relation to poor organisational culture and impact on people; they told us they had already identified this issue and were planning to conduct team building activities. This meant the management of the home had identified improvements were required however, they had not yet taken actions to effect the changes needed and manage the risks with low staff morale and performance.

The home manager in post was not registered with the CQC. Although efforts had been made to register the home manager and an application had been sent to CQC this was subsequently returned due to incompleteness and a new one had not been submitted in an acceptable timeframe. This meant the registered provider had failed to comply with a condition we had applied to their registration requiring them to appoint a registered manager.

Following our last inspection, we asked the registered provider to send us an action plan outlining the

actions they were going to take to meet the regulations and improve the quality of the service they provided. During this inspection, we asked the home manager if action plan had been successfully completed and they told us it had. However, the findings from this inspection did not corroborate this position as we found persistent issues with risk assessments, medicines and good governance, as stated above in this report.

During our last inspection, we were informed by senior management that Cleveland House was being supported by the registered provider's service recovery team. This support was provided on a regular basis through quality assurance visits and analysis of quality metrics, completion of audits, and direct support to the home manager, clinical lead and care manager. We saw the home had a service recovery plan initially created in December 2016 and last reviewed in June 2017 outlining the areas requiring improvement, actions required, who was responsible, timescales for completion and the expected outcome status. When we analysed these plans and outcomes against the information we gathered during inspection, we found these had not been robust or effective in driving improvements.

For example, the service recovery plan stated the service should ensure 'pre-assessment must detail all potential resident's risks and sign off prior admission by home manager. Care plans, risk assessments are completed in 72 hours'. The outcome of this action had been updated on the 31 March 2017 as being completed but being 'reviewed monthly'. However, as stated previously in this report, during this inspection we found the registered provider was still in breach of regulation 12 due to insufficient or lack of risk assessments. The recovery plan indicated the service's staffing levels had to be regularly reviewed and 'maintained as a maximum of 7/5/4 health care assistants (minimum 6/5/4) due to layout of the building' but during this inspection we found substantial concerns in relation to staffing levels and its impact on people. The recovery plan also had dedicated actions in relation to the management of medication which included regular reviews by the quality manager; however, our findings during this inspection showed medicines were not being managed safely and people were being put at risk. This meant the systems in place identified the areas for improvement and actions to take however, the systems of governance were not robust to implement changes, home manager's oversight was not robust and this was having a negative impact on the overall quality of the service.

During our inspection, we found the registered provider had not maintained accurate, complete and contemporaneous records in relation to people's risk assessments, care plans, food and fluid intake and weight loss management. This meant people could not be reassured staff would have access and use relevant information to provide person centred care and the findings from this inspection concluded this was impacting the quality and safety of the care provided to people.

The evidence above demonstrates the registered provider was in continuous breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Under the Care Quality Commission (Registration) Regulations 2009 registered providers have a duty to submit a statutory notification to the Care Quality Commission (CQC) regarding a range of incidents. During our inspection we identified three safeguarding incidents which the registered provider had failed to notify us. It is an offence not to notify CQC when a relevant incident, event or change has occurred. Therefore, this constituted a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw feedback from the last satisfaction survey to people and relatives was recorded in the reception area. We saw people and relatives had asked for more wheelchairs and were told these had been ordered. Families who lived away or abroad requested regular updates via email about their family members' condition which the provider assured them would continue to be provided via email. We inspected the minutes from the last two residents and relatives meetings in February 2017 and June 2017 respectively and

we found general aspects of the management of the home were being discussed such as activities, catering, staffing and resident of the day. This meant the registered provider was seeking feedback from relevant people.

Under the Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2014, registered providers have a legal duty to display the ratings of CQC inspections prominently in both the office and on their websites. During our inspection we found the registered manager was displaying their ratings as required.