Your Health Limited

Cedar Court Nursing Home (Dementia Unit)

Inspection report

Cedar Court Care Home
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Ratings

Overall rating for this service	Inadequate

Is the service safe?	Requires Improvement
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

This inspection took place on 18 January 2018 and was unannounced. The service had been in special measures since the inspection on 24 January 2017 and again from the inspection on 22 June 2017. At this inspection the overall rating for this service is Inadequate which means it will remain 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

Cedar Court Nursing Home (Dementia Unit) has had positive conditions on their registration since March 2017. This meant that they were required to report to us what improvements they had made every two weeks. The provider complied with this requirement and at this inspection we saw that some further improvements had been made as the provider had reported. However, they had not completed all of the actions that were detailed and this impacted on the safety and wellbeing of people who lived at the home. Therefore, we will retain the positive conditions on the provider's registration until we are satisfied that significant improvements have been completed.

Following the last inspection, we met with the provider 18 July 2017 to confirm what they would do and by when to improve the key questions safe, effective, responsive and well led to at least good. At this inspection we found that some improvements had been made, however further improvements were required and we also had additional concerns in some areas.

Cedar Court Nursing Home (Dementia Unit) is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care is provided in one building with an accessible, secure garden. Some of the people are cared for in a male only environment on the first floor, called Bretby View. There are two communal areas on this floor and a further two communal areas on the ground floor. The home provides accommodation and nursing care for up to 50 people who

are living with dementia. There were 36 people living at the service when we visited; including 14 men were living in Bretby View.

There had not been a registered manager in post for over one year. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was a recently appointed manager who was in the process of completing their registration with us.

We found that risk was not managed sufficiently to ensure that people were kept safe. This was an issue at our three previous inspections. Medicines were not always managed and administered to ensure that people had them as prescribed. Systems had been introduced to protect people's skin from pressure wounds but these were not always followed or clearly documented. When people were losing weight the provider did not always respond adequately to maintain the person's wellbeing. Records which were in place to support the care people received so that staff understood what they needed to do were not always up to date or clear.

Staff had an understanding of how to recognise and report any suspected abuse. Concerns were investigated in partnership with safeguarding authorities when needed. However, the provider did not always learn from when things went wrong to ensure that action was taken to avoid it happening again.

At the previous inspection we found that the provider ensured that there were enough staff deployed but because a lot of them were from an agency they did not always know people well enough to meet their needs. At this inspection we found that care staff were more consistent and this had helped to establish caring relationships and an understanding of how to support people when they were distressed. However, there were still difficulties in recruiting and retaining nurses and this impacted on the communication with partner organisations to ensure that people's healthcare needs were met. It also meant that at times there was not sufficient oversight of daily records to ensure that action was taken to keep people safe and well.

Quality improvement systems had been embedded and audits were regularly completed. However, they did not always lead to action being taken to improve the quality of the service. At the previous three inspections we found that the Mental Capacity Act 2005 (MCA) was not fully embedded and we found that this was still the case at this inspection. Capacity assessments did not include people who were legal representatives in decision making. They had also not completed capacity assessments for some important decisions. Some people had safeguards in place which staff did not understand or comply with.

People did not always have enough stimulation and engagement in activities. Their dignity was not always upheld and respected.

Complaints were responded to in a timely and open fashion in line with the provider's procedure. There was a record of the outcome and the provider ensured that people were happy with it.

Staff had positive relationships with people. Families were welcomed to visit and felt that there was more effort from the provider to hear their feedback through meetings and surveys.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.
People were not always protected from risk of harm; medicines were not always administered as prescribed and risks were not effectively managed. Lessons were not always learnt when things went wrong. There were not always enough staff with the right skills available to support people. Staff understood how to protect people from abuse. The home had systems in place to keep it free from infection.

Is the service effective?

Inadequate

The service was not effective.
When people were not able to make their own decisions this was not always assessed to ensure the decisions were made in their best interest. People's diets were not always monitored to ensure they had enough to eat. Staff did not always have the skills required to support people effectively. People's health was not always reviewed as effectively as it could be to ensure their wellbeing. The environment was planned around people's needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.
People did not always have their dignity upheld and respected. Staff developed caring relationships with the people they supported. Important relationships with families were supported.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.
People did not always receive care that met their needs and preferences. There were not always enough activities provided to engage them. Complaints were managed to ensure that they were responded to and that people were happy with the outcome.

Is the service well-led?

Inadequate

The service was not well led.
The systems in place to monitor and drive quality improvement

were not effective in implementing change. The provider had not made the required improvements since the last inspection. The provider was transparent with people and families and met with them regularly. Staff were supported in their jobs through supervisions and team meetings.

Cedar Court Nursing Home (Dementia Unit)

Detailed findings

Background to this inspection

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

The inspection took place on 18 January 2018 and was unannounced. The inspection visit was carried out by one inspector and a specialist adviser. The specialist adviser was a nurse with expertise in dementia care.

On this occasion we did not ask the provider to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. This was because the provider was sending us two weekly updates on progress and improvement from a condition which was added to their registration after the inspection on 24 January 2017. We also ensured that we gave the provider time to tell us about future plans during the inspection visit.

We contacted two commissioners of the service prior to the inspection to gain their feedback and to review the improvement action plans they had in place with the provider. We also spoke with one healthcare professional who had regular contact with the service. We used all of this information to assist us to formulate our inspection plan.

During the inspection visit, we used a range of different methods to help us understand people's experiences. The majority of people who lived at the home were not able to verbally communicate with us. Therefore we observed the interaction between people and the staff who supported them in communal areas throughout the inspection visit. We also spoke with four people's relatives about their experience of the care that the people who lived at the home received.

We also spoke with the manager and the quality manager; seven care staff, one nurse and a visiting health professional. We reviewed care records for six people to check that they were accurate and up to date. We looked at medicines administration records for nine people. We also looked at the systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement. We reviewed audits and quality checks for medicines management, accidents and incidents, complaints, safeguarding, weights management and skin care. We also looked at two staff recruitment files.

We asked the provider to send us the staff training matrix and an update on some people's planned care. This was sent to us in the timescale requested.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we found that risk was not always managed to protect people from harm, and there was a breach of Regulation 12 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. At this inspection we found that some improvements had been made in some of the areas we identified. However, we found further concerns and improvements were still required to keep people safe.

Medicines were not always administered as prescribed. Some people needed to have their medicine at specific times of the day to ensure that it was effective. We saw that one person received the medicine that they should have had at 8am over three hours late at 11.20 am. When we spoke with the member of staff they recognised that they would need to alter the time of the next dose to ensure that the medicine was administered as prescribed, with four hourly intervals. The timings and intervals of this medicine are important for it to be effective in treating the condition; in line with guidance from the National Institute for Health and Social Care Excellence (NICE). When we reviewed the medicines administration record (MAR) later in the day we saw that the member of staff had signed for the next medicine at 12pm and had not recorded if it was given later as they said that they would. When we spoke with them they confirmed that they had given it at lunchtime. This meant that the person did not receive their medicine when they should and it could impact on the management of their condition.

Another person was prescribed a medicine to be taken at night. When we reviewed the MAR we saw that it had not been administered at all for over three weeks and staff had recorded that this was because the person was sleeping. We were unable to find out if they had not had it for longer than that period because staff and the manager were unable to locate previous MARs. This demonstrated to us that staff had not understood the importance of this medicine and not taken action to ensure that it was administered at a different time of night when the person was awake.

Some people were prescribed topical creams to protect and treat their skin. We saw that one person's cream was dispensed four months previously. It was not dated when opened. The cream should not have been used after three months from opening. However, as no date of opening was recorded it was difficult to ascertain if the cream should still be used or not. This meant that the systems in place to manage the integrity of medicines were not always effective.

When we reviewed MARs we saw that there were gaps in signatures. For example, one person had only two signatures recorded over three weeks of their records to evidence that the medicine had been given, although it was prescribed to be taken daily. Another person had used an inhaler to assist them to breathe. There were also gaps in their recording and we were unable to ascertain whether they had taken it. This meant we could not determine if they had received their medicine as prescribed.

At our last inspection we found that the plans in place to manage people's skin were not always followed to protect it from damage. At this inspection we saw some improvements had been made however further improvements were needed. Staff we spoke with understood the plans that were in place and could tell us who needed to be repositioned regularly to reduce pressure on their skin. We reviewed records and saw

that the people were moved in line with the plan. There was a record of the turns and the treatment given and the provider had liaised with other health professionals to obtain expert advice. However, we saw that one person had a new area of concern recorded on the day before the inspection visit. There was no detail recorded about the nature of this area and it was only recorded as a 'sore'. When we spoke with staff about it they had not been given any guidance to manage this risk other than to 'reposition regularly'. This demonstrated to us that some staff did not take immediate action to ensure that a plan was in place to manage any areas of sore skin. We followed this up with the manager after the inspection and they told us that pressure relieving equipment had been ordered and that the area had been fully assessed.

We were notified by the provider in June 2017 that one person developed a pressure wound because the setting on their mattress was not correct for the person's weight. This was a specialised mattresses which reduces pressure for people's skin. At this inspection we found that another person had a pressure wound which was the result of a defective air mattress. We checked the mattress setting for this person and found that it was incorrect. This showed us that the systems in place to protect people were not always effective because the incorrect setting could mean that the mattress would not have been as effective as it should. This demonstrated to us that lessons were not always learnt from when things went wrong to avoid repetition.

Similarly, we had been notified that one person had not received one of their medicines for one month and this had been raised as a safeguarding concern. At this inspection we found that another person had also not received prescribed medicines for over three weeks. Again, this demonstrated to us that the provider's response to this error was not sufficient to prevent repetition.

This evidence represents an ongoing breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were enough staff deployed to meet people's needs but they did not always have the required mix of skills to do so effectively. Care staff knew people well and had time to meet their needs and to spend time with them. However, we also found that there continued to be difficulties recruiting staff to permanent nursing roles and that the home continued to be reliant on agency workers for these roles. One relative said, "There are still a lot of agency at night and we continue to be worried about that". We spoke with the manager about this and they said that they would be reviewing the staffing to include nursing assistant roles which would reduce the number of nurses required. Since the inspection visit, the manager informed us of two incidents which they referred to safeguarding that related to agency nursing staff and that they would be changing agencies and implementing the plans for a different staffing structure.

At our last inspection we found that some people were not supported to move in safe way to avoid the risk of harm to them. At this inspection we found that this had improved. One member of staff we spoke with told us, "We have had training in moving people and have also been observed doing it to make sure we are doing it safely". We saw that people were moved in line with the risk assessments that had been created.

Staff understood how to recognise and report suspected abuse. One member of staff said, "I would look out for things like bruises. If I saw one I would record it on a body map and report it to the nurse or the manager". We reviewed safeguarding concerns and saw that when needed they had conducted an investigation in partnership with the local authority and that the outcomes were recorded for each incident.

Infection control procedures were in place to ensure that people were kept safe from harm. We observed that staff used protective equipment when they supported people or served food. We saw that there were separate colour bins which staff explained were to collect clinical and non clinical waste. We also saw that

there were domestic staff available to clean and respond to any concerns. There were regular infection control audits and reviews in place.

The provider followed recruitment procedures which included police checks and taking references to ensure that staff were safe to work with people. One member of staff told us, "I had my interview a while ago but I have not been able to start until my references and police checks came through". We looked at recruitment files and saw evidence that this was completed.

Inadequate

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that 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). At the last inspection we made a recommendation for the provider to ensure that all capacity assessments were up to date and reflected people's abilities to make their own decisions. We checked whether the service was working within the principles of the MCA at this inspection, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The provider had employed a consultant to undertake some mental capacity assessments for people who were no longer able to make their own decisions. However, we found that these assessments did not always include people who should legally have been consulted. Some people living at the home had a lasting power of attorney (LPA) in place. This is a legal tool that gives another adult the legal authority to make certain decisions for the person when they became unable to make them for themselves. We saw that some people had these in place to manage their finances or to make decisions relating to their health and welfare. However, when the provider arranged for the best interest decisions to be assessed they did not include those people named in the LPA. This meant that they were not complying with the requirements of the MCA.

In addition, some decisions had not been considered under the MCA. For example, we saw that the last records of people's influenza vaccines were from 2016. We were told that people had received a vaccination in 2017. There was no record that people had consented to this or that the decisions were made in their best interest if they were unable to consent. This demonstrated to us that staff did not always recognise the restrictions in place on people's liberty.

Some people had a DOLS in place and there were further applications with the authorising organisation. When we asked staff who they supported under a DoLS they were unable to tell us. We saw that one person's DoLS had recently been approved and put into their care plan. When we reviewed it we saw that it had three conditions on it. The manager and other staff were not aware that these conditions were in place and no action had been taken to comply with them. This meant the provider had not ensured that staff were trained to understand the specific requirements of the DoLS and were not complying with all of the authorisations.

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

People did not always receive the food and drink they needed to keep them well. We observed one person sit with a meal for one hour and twenty minutes. During that time they ate one forkful of food. Staff were in

the vicinity and walking past. One member of staff said, "Well done, you are really enjoying that". When we spoke with another member of staff they reported that the person had eaten well. We had to tell staff that they had only eaten a very small portion of their meal. A second person spent time in their room during the inspection visit. When we went to speak with them at 3.20pm they were sat beside an almost full plate of food which was cold and congealed. We asked staff to attend to the person and they said that they were not aware that the person had not eaten their meal. This meant that they had not been supported to eat their lunch and staff had not responded to the fact that they had not eaten nor offered them an alternative.

We looked at records that were maintained for the amount of food and fluid that people received and found that they were not always accurate. For example, when we spoke with one person they said, "I have eaten my meal but I don't want the dessert". We saw that the full dessert was on the table beside them. When we reviewed records we saw that the staff had written that they had eaten ¾ of their meal and all of their dessert. This meant that we could not be assured that the systems in place to monitor people's food and fluid were effective.

When people were nutritionally at risk because they were losing weight the recommendations to supplement their diet were not followed. For example, when we spoke with one member of staff about one person's weight loss and their diet they told us the person was receiving fortified food. Fortifying food means adding high calorie ingredients such as milk and cheese to food to enrich it and make it more nutritious. The manager confirmed that they had also been told that the person was receiving fortified food. When we spoke with staff in the kitchen they told us, "We fortify milk here and they use that in hot drinks. The care staff fortify individual meals when they serve them". We spoke with one care staff about this and they said, "We used to have milk and cheese to add to people's meals but we haven't had that for a while". This demonstrated to us that although staff thought that people were receiving fortified meals they were not. This meant that they were not receiving the additional nutrients that may be required for their wellbeing. This is not in line with best practise or national guidelines.

The mealtime experience was lengthy and some people had to wait for over one hour for support whilst people near them ate their meals. Some people had their food pureed to reduce the risk of them choking on it. The food was prepared in moulds so that it looked appetising and represented what it would look like in 'normal' diet. We saw that two people received their meals in this format. However, when supporting them with their meal we observed both care staff mix the moulds together and offer the people they were assisting food which was a mixed, brown presentation. This meant that the effort to present the food differently was not maintained by care staff.

This evidence represents a breach in Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not always have the skills and experience required to meet people's needs effectively. For example, staff had received training in MCA and could talk to us about what it meant. However, they had not been supported to understand the direct impact it had on the people they supported because they did not know who had a DoLS in place or how to comply with them. Furthermore, we saw that a healthcare professional visited to complete a procedure for one person. When we spoke with the manager they told us that this was because they did not currently have any staff who were competent to conduct this. This demonstrated to us that the provider did not always ensure that they had staff who had the required skills to meet people's needs effectively. Another health professional told us, "We have had to ask our district nursing team to visit to do this procedure which is difficult around their already busy schedules".

The provider did not always work effectively with other healthcare professionals to ensure that people were

kept well. One healthcare professional told us, "The lack of consistency of staff with the use of agency nurses on a regular basis, and the lack of communication between these nurses' results in either duplication of work or poor information sharing. For example, there are times when the same resident has appeared on our duty list after the problem which has been addressed". We saw that records of people's health were maintained but not always reviewed or communicated effectively. For example, on the day we visited we were told by the manager that some people had been unwell. When we reviewed records and spoke with staff we found that the number of people was higher than had been reported. This meant that we could not be sure that there was clinical oversight of the records that staff completed for people.

The environment was planned to meet people's needs and we saw that some refurbishment had been completed since our last inspection. One member of staff told us, "We replaced the carpet downstairs for non-slip flooring to help reduce the risk of falls and also because it is easier to keep clean". We also saw that a second lounge had been created on Bretby View to give people more space and a quieter environment to sit in. One relative we spoke with said, "The room is really nice and has a lovely view; I think the birds in the cage are a really nice addition for people".

Requires Improvement

Is the service caring?

Our findings

People's dignity was not always respected. One person had their meal in their room and when we went to speak with them we saw that they did not have any footwear on and their feet were in spilt coffee. They had food on their face and clothes. We intervened and asked staff to attend to the person. Another person was cared for in bed. We spoke with their relative who said, "We have asked for their bed to be turned around so that they are not isolated and can see people passing in the corridor but this hasn't happened yet". We saw that the person was facing into their room. This demonstrated to us that the provider did not always ensure that people's dignity was embedded in their care.

People had caring relationships with the staff who supported them. One relative we spoke with said, "The staff are good and relationships have improved by having regular staff on Bretby View when they can". We saw that the staff knew people well and we observed that they comforted people. For example, when people were less able to communicate staff smiled and reassured them and we observed staff stroking one person's hair to reduce their anxiety. People's independence was encouraged when they could do so safely. For example, we saw that one person was eating their meal with their fingers and some of it spilt. When we spoke with staff they said, "[Name] doesn't like to be assisted or to sit at a table. When they eat like this they eat well and are independent so it has been agreed to support them this way". This showed us that people made choices about their care which promoted their independence.

Staff knew people's life histories and their families. One relative we spoke with told us, "I visit very regularly and the staff always ask about my wellbeing as well. They talk with me about [names] life so that they can talk to them about it when I am not here". We saw that relatives visited when they wanted to and that some made arrangements to take people out. This demonstrated to us that attention was given to supporting people to maintain important relationships.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive care that met their needs and preferences. We saw that one person needed a nurse to treat them before they left their room to join other people in communal areas. Staff told us that it was part of the person's plan that they should go into communal areas after they were supported by the nurse, and that this should have happened each day. We saw that on the day of the inspection visit the person remained in their room because the nurse did not treat the person as required to ensure they were safe to be in the communal area. We monitored them throughout the day including raising our concerns with staff at 3.20pm. When we last checked at 5.15pm they had still not received the support and had remained isolated in their room for the duration of the day.

Another person was in their bed for the full day of the inspection visit. When we asked one member of staff about this they said, "During a hospital stay their legs seized and we are now waiting for a health professional assessment for a hoist. It has been over two weeks". Staff told us that prior to their hospital admission; this person had been able to get up from their bed; however they had now been confined to their bed for over two weeks as they had not been assessed to use a hoist for transfers. We raised this with the manager who told us that they were not aware of the situation. . After the inspection, they told us that staff had previously been told that only an occupational therapist could assess someone for a hoist. They had ensured that the person had now been risk assessed to use the hoist and could get out of bed.

Guidance in care plans was not always followed nor reviewed to ensure that it was accurate and up to date. For example, in one person's records it stated, 'Weigh monthly and any loss of 3kg and above in a four week period report to GP'. We found that from the person being weighed in September until they were weighed again five weeks later they lost 5kg. At this point staff did not review the person's care plan. When we reviewed this with the provider after the inspection they told us that the person had been classed as being for end of life care by the GP in October. We saw that there was no end of life care plan put in place and staff were given no further guidance on meeting their needs during this period; including nutrition and hydration. There was no further record of their weight until January which was over 10 weeks later. a further 10.9kg. This equated to a 24% loss of their body weight from September 2017 to January 2018. The provider told us that at this point it was decided that the person was no longer on end of life and so a referral to a dietician was made. Furthermore the information in the care plan had been reviewed in December and stated that, '[Name] is able to eat a normal diet and drink normal fluids'. However, we were told and we observed that the person ate a pureed soft meal. This demonstrated that the information was not up to date..

Some of the information that was recorded to direct staff how to support people was unclear or incorrect. For example, one person's pressure wound was graded as a 4 in one record and as a 3 in their care plan. This meant that when staff attended to the person's skin the information available to them was inconsistent.

Other records were not completed to be able to review what support people might need. We saw one person behave in a way which could cause themselves or others harm when they were distressed. Staff were able to reassure them and we saw that this was in line with their care plan. However, it was also

written that their behaviour should be recorded so that it could be reviewed. We saw that staff did not record the behaviour we had observed. We asked staff about this and they said, "We complete a tick chart to record behaviours". However, when we asked to see records of this they were not available. This showed us that staff did not always follow the systems put in place to monitor and review people so that their needs could be met effectively.

People did not always have enough encouragement and interaction to engage in activities. One relative we spoke with said, "People are usually sat in chairs and we don't see much activities". A second relative said, "I haven't seen any activities here at the moment. There used to be more; although I know somebody has just started a new job to do it". We observed that staff had time to sit with people and that some people were encouraged to join in with activities. However, we also saw that people sat for long periods of time in chairs with little stimulation.

This evidence represents a breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we asked the provider to make improvements to how they managed and responded to complaints. We saw that they had made these improvements. One relative we spoke with said, "I have raised some concerns and we had some meetings. We have now come to a compromise which I am happy with". We spoke with some relatives who had complained to the provider and they told us that they were still able to visit regularly and had maintained good relationships with the staff. We saw that complaints were recorded and this included what the outcome was and any learning for the provider from it. This meant that the provider followed their revised procedure to monitor and review complaints and take any action needed to resolve them.

There was nobody receiving end of life care when we inspected and so we have not reported on this.

Inadequate

Is the service well-led?

Our findings

At the last inspection we saw that the systems in place to measure and drive improvement were not fully effective and required improvement. We set positive conditions against the provider's registration which meant that they were required to give us regular updates on their progress towards improvements detailed on their action plan. At this inspection we saw that some improvements had been made but that the provider had not completed all of the actions to ensure that the home was well managed. They had also not sustained previous improvements; for example in medicines management. Furthermore, we had additional concerns around responsive care based on people's individual needs and their nutrition and weight management. This continued to have a significant impact on the people who lived at the home. For example, this was the fourth inspection that the provider was found to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This meant that they had not demonstrated that they could make the improvements required to ensure that people were kept safe. They also continued to require improvement for the fourth inspection in embedding the MCA and providing person centred care by ensuring that care plans were up to date.

We saw that the provider had embedded some systems and introduced further quality assurance systems to identify where improvements needed to be made. However, these were not effective as further areas of improvement were required and the provider had been performing below the standards required. For example, although the medicines audit had highlighted that one person had not received their prescribed medicine for a month no action had been taken to remedy this. Similarly, although there was now a clear system in place for measuring people's weights the oversight was not effective for someone to be accountable to take immediate action to prevent further weight loss. The provider did not demonstrate that they learnt lessons when things went wrong. We were notified in November 2017 of potential neglect because the provider had not taken sufficient action when a different person lost significant weight. We found the same situation at this inspection. Therefore, we do not have confidence that the systems that the provider implemented were effective in protecting people from abuse.

The service was registered to provide diagnostic and screening services for people. We had spoken with the provider previously and agreed that these services were not being provided. After the inspection they agreed that they would liaise with registration team to resolve this.

After the inspection on 24 January 2017 we imposed positive conditions on the services registration which required the provider to give us a fortnightly update on their progress in meeting the improvements identified. We have received these reports as requested. However, at this inspection we found that the provider's confidence in their improvements did not align with ours. For example, in the report sent to us on 20 November 2017 we were told that all internal audits were up to date and working well. However, we found that they were not always effective in highlighting errors. We were also told that all care plans were now up to date and reflected people's current needs which we found was not accurate.

The provider worked closely with partner organisations who provided regular guidance and support. They told us, "They are open to suggestions and take on board new ideas. We do see improvements, but they

continue to be slower than we would like to see". The provider had improvement plans in place with commissioners since January 2017 and had still not met all of the requirements on them. This had resulted in suspension of some funding for people with complex needs until they could demonstrate that they could meet them. After our inspection visit the commissioners completed another monitoring visit in February 2018 and found that the provider still had not completed all of the required action points.

The overall rating for this service is Inadequate. Providers should be aiming to achieve and sustain a rating of 'Good' or 'Outstanding'. Good care is the minimum that people receiving services should expect and deserve to receive. The service has been rated as 'Inadequate' or 'Requires Improvement' on four consecutive inspections.

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

There had not been a registered manager working at the service for over one year. The current manager had submitted their application to register with us as required. They had only been in post for a few weeks but had implemented some effective changes. For example, they had reviewed the staffing structure to consider nursing assistant roles to address the difficulties in recruiting nurses. They were also planning to introduce other systems which would give greater clinical oversight such as weekly falls meetings to review immediately any recommendations.

Relatives that we spoke with told us that there were regular meetings and some of them attended them. One relative said, "I do feel that they want to get families more involved and we have seen changes. For example, there are more food choices now and I think it is better quality". They told us that the new manager had introduced themselves. One relative said, "I have had a letter from the new manager saying they would like to meet and review the care which is really positive". We saw that surveys had been sent to relatives and the responses were mostly positive about the improved interaction with them and the openness which they shared their improvement plans with them. One survey said, 'If you had asked a few months ago the ratings would have been different. However, we are impressed with the efforts of the management team'.

Staff were supported and given the opportunity to contribute to the development of the service. One member of staff said, "We do have supervisions and we also meet regularly. If we have any ideas they are encouraged". Staff were aware of their responsibility to raise any concerns with managers and told us that they were confident they would be listened to.

The provider had reported significant events to us, such as safety incidents, in accordance with the requirements of their registration. It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed this in the home and on their website.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care and treatment did not always meet their needs or preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's nutritional needs were not always met.