Care UK Community Partnerships Ltd

Cavell Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

At our previous inspections in May and August 2017 we found that the service was in breach of regulations regarding the management of medicines. At this inspection we found that this breach continued. Our inspection of May 2017 also found that the service Required Improvement in the areas of Safe, Effective, Responsive and Well-led. At this inspection we found that the service still Required Improvement.

This inspection took place on 23 and 24 January 2018. The first day of the inspection was unannounced.

Cavell Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Cavell Court accommodates up to 80 people across three floors, each of which have separate facilities including a dining room and lounge. One of the floors specialises in providing care to people living with dementia and another provides nursing care. At the time of our inspection there were 54 people living in the service.

The service is required as part of its registration to have a manager registered with the CQC. 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. On the dates of our inspection there was no registered manager in post and the prospective candidate resigned during our inspection. On the second day of our inspection the provider brought in a manager registered at one of its other services. They have told us that this manager will be registering with CQC to manage Cavell Court. This is the second time the service has been rated 'Requires Improvement'.

We discussed the issues we had identified with the management team. They told us they had recently become aware of a failure in the management systems and told us the actions they were taking and had planned to address them. However, we concerned about the length of time this took to identify and the effective oversight of the service during this period which meant the breaches continued. We have therefore rated the service Inadequate in Well-Led.

At our previous two inspections we identified that medicines were not administered as prescribed. At this inspection we found that improvements had been made in some areas but that concerns persisted with the service's management of medication. There were still medicine errors arising and we also observed, and were told about poor practice when staff were administering medicines which potentially placed people at risk of harm.

People told us there were not sufficient staff to meet their needs. We were given examples of how this impacted on people's care, for example slow response to call bells. We also observed occasions where lack

of staff presence meant that people were not getting the care and support they required.

Prior to our inspection we had received concerns from people about how complaints were dealt with and were given examples of where the service had failed to respond to complaints according to its own complaints policy. At the inspection we spoke with the management team about the service complaints policy and procedures. They explained to us why they believed there had been shortfalls at the service and what they were putting in place to address these concerns.

The service used a high number of agency nurses. Agency nurses did not always have full information about people's care needs and this gave an increased risk of people not receiving their assessed care and support needs. The service had identified concerns with the quality of care provided by agency nurses and met with the agencies to discuss expectations.

Care documents contained care plans and risk assessments relevant to the care and support people provided. However, the risk assessments did not always contain sufficient information to ensure care was delivered safely. We found some instances where risk assessments and care plans were not being followed by staff when providing care and support. Care planning was inconsistent with some examples of good care plans and others lacking information.

Care staff we spoke with had a good knowledge of different types of abuse and how it should be reported. The management team explained how they would be addressing concerns raised with us about the service's poor response to safeguarding investigations.

Staff knowledge relevant to the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS) was inconsistent with some staff being able to give us a good explanation and others having no knowledge. The service had made DoLS applications to the local authority.

Staff received an induction into the service and relevant training in a variety of areas. However, we observed occasions where staff did not support people with dementia appropriately.

People had mixed views on the quality of the food provided. The provider had recognised this and had taken steps to address concerns with a survey and observations of the mealtime experience. Staff demonstrated a good knowledge of people's dietary needs. However, recording of people's fluid intake was inconsistent which meant that we could not always be certain that people were receiving sufficient fluid.

The environment met people's needs. All rooms had en-suite facilities and there were quiet areas for people to meet family and friends. People told us that care staff were kind and compassionate and that their privacy and dignity was respected. Individual staff were able to tell us about people's backgrounds and how they used this knowledge to develop relationships with people.

People had mixed views as to the quality of the opportunities for social engagement and activities. This was related to the area of the service people resided in with people living on the ground floor being more satisfied and engaged with activities than those on the nursing floor.

People were supported to make decisions about their preferences for end of life care. We received positive feedback from relatives about end of life care provided at the service.

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.

We were not assured that people always received their medicines safely or as prescribed.

There were not always sufficient staff with the required skills to meet people's needs.

Staff were not always aware of the risks to people from receiving care and support. Actions put in place to mitigate risk were not always carried out.

Staff were aware of safeguarding procedures.

The service had an infection control policy and was clean and odour free.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Not all staff were aware of the requirements of the Mental Capacity Act 2005.

Staff received an induction and support to gain further qualifications. Although staff received training, staff were not always confident in dealing with people's specific healthcare conditions.

People had mixed views on the quality of the food provided. Staff had a good knowledge of people's dietary requirements.

The design and decoration of the service met people's needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff treated people with kindness, respect and compassion. However, their ability to do this was sometimes restricted by the time they had available.

People were not always able to express their views as to how they wished to receive their care and support.

People's privacy and dignity was respected.

Visiting was not restricted and there were areas within the building for people to enjoy time with friends and relatives.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Information in care plans was not always comprehensive and up to date.

There were varied views about how the service supported people with social activities and social engagement.

We received positive feedback where the service had provided end of life care.

Is the service well-led?

Inadequate

The service was not well-led.

Failings identified at previous inspections had not been addressed effectively.

Staff did not always feel supported by the management team.

Quality assurance processes did not always identify shortfalls.

The service was pro-active in developing links with the local community.

Cavell Court

Detailed findings

Background to this inspection

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

This inspection took place on 23 and 24 January 2018. The inspection team consisted of three inspectors, a specialist medicines inspector and two experts-by-experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our experts by experience had experience of supporting a relative living with dementia.

Before the inspection we looked at all the information we held about the service. This included information about events happening within the service which the provider or registered manager must tell us about by law. We also looked at previous inspection reports and notifications sent to us by the service.

During our inspection we spoke with 10 people using the service and 14 relatives. We observed how staff supported and interacted with people throughout the inspection. We spoke with nine care staff, two nurses, a kitchen assistant, the deputy manager, the operations support manager and the regional director.

To help us assess how people's care and support needs were being met we reviewed nine people's care records. We also looked at other records regarding the management of the service, for example, risk assessments and medicine records. We looked at four staff personnel files and records, this included recruitment and training records. We looked at the systems for assessing and monitoring the quality of the service.

Requires Improvement

Is the service safe?

Our findings

Our comprehensive inspection in May 2017 found that the service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service did not ensure there were sufficient quantities of medicines to ensure the safety of people and to meet their needs. An inspection which focussed on medicines in August 2017 found that the service continued to be in breach of this regulation as medicines were not always available for people to receive them as prescribed.

At this inspection people and relatives had mixed views as to whether they received their medicines as they preferred. One person said, "They show me my medication. I take it and they watch me." However, another person described how they had to wait for the medicine saying, "I like to have my tablets (pain relief) by 10pm, sometimes I call them (using call bell) and they're [staff] on the floor. I don't want to go to bed and not get my tablets before I fall asleep."

Records showed that previous issues relating to the availability of medicines and obtaining them in time to ensure people's continuous treatment had improved and that this no longer presented significant risk. However, the service had recently identified and reported medicine errors and discrepancies including incorrect and missed doses of medicines given to people. On the day of the inspection staff identified a further two medicine discrepancies and we noted some others where records did not confirm people had received their medicines as intended by prescribers.

A relative of a person living at the service told us about recent medicine incidents where some of the person's medicines were found on the floor in their room and had not been properly given to them putting them at risk. The relative said they had reported this to staff but we found no records of these incidents.

We observed part of the morning medicine round and observed one member of staff giving people their medicines safely and in a caring manner. However, we also observed another member of staff on another floor following unsafe procedures when giving people their medicines.

Supporting information was available for staff to refer to when handling and giving people their medicines. There was personal identification and information about known allergies and medicine sensitivities and information about how people preferred to have their medicines given to them. When people were prescribed medicines on a when-required basis there was written information available to show staff how and when to give them to people to ensure they were given consistently and appropriately. There were additional records in place to ensure safety for people prescribed medicines in the form of skin patches. However, these records were not always completed to show that safe procedures for the skin patch application and removal had been followed.

One person told us that staff were not aware of the risk associated with their care and support. They said, "Today was a wonderful example of this, we had three staff this morning to get me up and get me out of bed but they turned out to all be agency staff. They did not know how to use the hoist. They said we'll have to get a nurse, but she was not there. I wanted to go to the toilet so they worked it out for themselves. I had to tell

them what to do." Staff we spoke with were not always aware of the risks to people recorded in care plans. One member of care staff said, "I have never read a care plan since I have been here. I know how to care for someone by staff telling me." Another member of care staff said, "From time to time we get to read care plans and risk assessments. Sometimes it's a bit busy. I probably have more practical skills than knowledge but I am good at my role." However, another member of care staff said, "We have time to read care plans and risk assessments. We make time. I feel I am knowledgeable in people's needs and I do get compliments."

Staff lack of knowledge about risks to people was demonstrated when we saw a person trying to come out of their room. A carer said, "Come on" and took their hand and began walking along the corridor. We noticed that the person had a walking frame in their room and asked the member of staff if the person needed it. They replied, "I've never seen anyone use it." They retrieved the walking frame and began using it anyway. We asked another member of care staff if the person should use their walking frame and they confirmed that they should. Not using their walking frame put the person at increased risk of falling.

Care plans contained an assessment of risk such as developing pressure areas, becoming malnourished and from specific conditions such as diabetes. We found that the assessment of these risks was inconsistent and in some cases the actions put in place to mitigate the risks were not being carried out. We looked at the records of two people who lived with diabetes. For one person there was detailed information about how their diabetes was monitored and managed. However, for the second person the care plan lacked information. It did not detail if the person needed to have their blood glucose levels monitored and did not provide guidance for staff on what to look for if a person's blood glucose levels were too high or too low, or what action to take. For another person who was at risk of developing pressure ulcers their care plan stated they should be re-positioned every two hours but their re-positioning chart in their room stated they were to be re-positioned every four hours. We also saw for four days that there were gaps every day in the recording on the chart where no repositioning had been recorded for periods of between five and ten hours. This person had a pressure ulcer. This could have developed due to a lack of re-positioning and may become worse if regular re-positioning was not taking place.

Actions to mitigate risks to people were not always put in place promptly. One person's relative told us that the person had two pressure ulcers. They said, "They required bed rest for two weeks, the reason for not getting [relative] up was the nurse had said they needed to order an inflatable cushion." The relative said that the person had been wanting to get up in a chair for the last week but had not been able to due to the pressure cushion not being available. However, following a visit from the doctor on the day of our inspection they had been told that a cushion could be made available immediately from another floor in the service.

This represented a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored securely for the protection of people who used the service and at correct temperatures.

At our comprehensive inspection in May 2017 we found that staffing had improved from the previous inspection in July 2016 but still required further improvement. At this inspection people told us there were not sufficient staff to meet their needs. One person said, "There's no one about, it's quiet in the evening. I get a bit anxious at times when they're [staff] a long time coming." They then went on to tell us that, when responding to their call bell recently, a member of care staff had said, "I can't help you now, I'm too busy with other patients." A relative told us, "Staff are so stretched a lot of the time, there's a lot of times [person] is lying in a wet or messy bed." They went on to tell us they regularly changed their relatives clothing and

removed soiled bed clothes.

People told us that staff did not always respond promptly when they used their call bell. A relative said, "I rang the bell because [relative] had wet her bed. I went out and after 30 minutes came back and nothing had been done and someone had switched the bell off." Another person said, "Buzzers go and it elevates to the emergency level. This is a regular thing, but not today of course." We were told that it was not unusual for staff to respond to a call bell, switch it off and tell the person they would return, but did not come back to provide the required support. The deputy manager told us that they monitored call bell response times and that response times had improved.

We observed occasions during our inspection where lack of staff presence meant that people were not getting the care and support they required. For example, during the lunchtime period we observed a person drinking from the jug of juice which was on the table for all to use. The only member of care staff in the dining room at the time was serving food and did not notice this.

Most care and nursing staff expressed the view that there were not sufficient staff to meet people's needs. One staff member said, "It would be better if we had an extra staff member until lunchtime so we have two staff to do personal care for those who need assistance from two staff. One staff member could then support those who require single assist and one person support with breakfast. When it is busy and the call bells are ringing it is hard. We can't leave people to answer call bells. The afternoon is quieter. We have told management about the staffing and apparently everything is going to be sorted and we are told we are brilliant. They think with three staff we are fine and sometimes we are when it is quiet, but when it is busy you can't do everything you are supposed to and look after people how you should." This reflected the view of the majority of staff we spoke with.

The service regularly used agency nursing staff to provide care and support. The deputy manager told us that agency nurses were given a thorough handover by staff from the previous shift before they started their shift. One agency nurse we spoke to on the second day of our inspection told us, "I started last week and I am doing regular shifts. I have done more than eight shifts. I had an induction and was shown the rooms, dining area sluice and codes for the door, medication and controlled drugs cupboard. The manager showed me how to complete the wound charts. I got told the basic details of the wound charts. The night nurse showed me everything and I feel I was shown enough to be able to do the shift. I have no problems." However, another agency nurse who was carrying out their first shift at the service told us that they had not had a full handover from the previous shift. They told us that a night carer had told them where to sign in, the fire panel and how the rooms were numbered. They had had no introduction about the residents. They had no access to the computer based care planning system. They said they had been given printed copies of care plans but had not had a chance to read them before taking over the shift. Although we observed the nurse dispensing medicines when we spoke with them they were not aware of one person's particular requirements around medicines. The lack of a thorough consistent handover and induction for agency staff meant that staff may not have the knowledge to meet people's individual needs and an increased risk of people not receiving safe care and support.

This represented a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the deputy manager and the operational support manager about how the service assessed staffing levels. They told us that they used a dependency tool which assessed people's care needs and gave the levels of staff needed on each unit. Staffing levels could then be adjusted according to need for example, if a person needed to be taken to hospital.

We asked the management team about the high use of agency staff in the service and how this could contribute to poor care standards. For example, agency nurses not being aware of people's individual medication or care needs. They told us they used a limited number of nursing agencies and had had recent meetings with these agencies which addressed the standards that nurses provided should demonstrate. The management team also described the handover that an agency nurse should receive when taking over a shift and gave us a form which needed to be completed. They were not aware that shift handovers to agency nurses were not always taking place as required.

Care staff had a good knowledge of the different types of abuse and how it should be reported. One member of care staff said, "I would feel confident to report bad practice and I would speak to my line manager. If that didn't work I would take it to a higher level." Another member of care staff said, "I have had training in safeguarding. I would report any abuse to someone in charge. I would go higher if they didn't do anything. If a manager was involved I would tell CQC." They were not aware of reporting concerns to the local authority. Another member of staff asked about abuse and safeguarding processes demonstrated a good knowledge and showed us a card with the categories of abuse recorded.

Concerns had been raised with us by commissioners regarding the service's poor response when investigating safeguarding incidents. We spoke with the management team about our concerns. They told us the reasons they believed this had occurred and explained the action they had taken to ensure the service improved in this area.

There were effective systems in place to complete all the relevant pre-employment checks including obtaining references from previous employers, checking the applicant's previous experience, and Disclosure and Barring Service (DBS) reports for all staff. DBS helps employers make safer recruitment decisions and prevents unsuitable people from being employed. We found that recruitment and selection procedures were in place and were followed consistently. Relevant pre-employment checks had been completed to help ensure that the applicant was suitable for the role to which they had been appointed before they had started work.

The service had an infection control policy and staff received training in infection control during their induction. During our inspection we did not notice any unpleasant smells. People's rooms and communal areas were clean, fresh and uncluttered. Food dropped onto the floor during lunch was observed to be cleaned up shortly afterwards. We observed a member or staff entering a person room to check if the deep cleaning of the carpet by an outside contractor had been carried out to the required standard.

Requires Improvement

Is the service effective?

Our findings

Our inspection in May 2017 found that the service Required Improvement in Effective because improvements were needed in the assessment of people's capacity to make their own decisions. At this inspection we found that assessments had improved but staff knowledge about the Mental Capacity Act 2005 (MCA) required improvement.

The 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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We asked the deputy manager if they had made any applications under the MCA and if there were any DoLS authorisations in place. They told us that applications had been made where appropriate, some were in place, but that the majority were waiting authorisation by the local authority.

Staff had mixed knowledge in the area of the MCA. One senior care assistant, demonstrated a good knowledge by stating, "We can't say someone hasn't got capacity as we have to assume that they have and can make their own decisions, if we make them we make decisions in their best interests. It is specific to different decisions, for example, someone may have the capacity to decide what they want for dinner but not about their finances." However two other members of staff we spoke with had poor knowledge and another told us that they had not had any training and did not have any understanding of the MCA.

We observed staff seeking people's consent before providing care or support. For example when position a wheel chair at a table the member of staff asked, "Would you like the footplates moved?" and the person replied, "No, I'm OK thank you."

Staff did not always have the skills necessary to support people living with specific conditions. We observed two incidents where staff did not have the skills required to provide effective support to people living with dementia. The first time we saw a person saying to a member of care staff, "Can you phone me a taxi, I want to leave." The member of care staff replied, "The phone is busy at the moment." After the person had left the member of care staff said, "I feel bad because I don't know what to say to him." The second time we observed a person asking a member of staff for their father. The member of staff replied, "Your father is not here and neither is mine." The person replied, "I'm interested in the way you treat my father." The member of staff again replied, "Your father's not here [person]." This demonstrated that care staff did not have the knowledge required to effectively support a person living with dementia. We asked the management team

what training care staff received in supporting people with dementia. They told us that they did e-learning during their induction and received a yearly refresher. They also told us that a dementia strategy was being implemented in conjunction with the University of Worcester and that, to date half of the staff team had been trained with further training planned.'

When beginning employment in the service staff received an induction. This consisted of two weeks dedicated training and then carrying out shadow shifts. Induction covered areas such as moving and handling, infection control, risk assessment and equality and diversity. One member of staff said, "I help with the induction of new staff as I am a qualified assessor. New staff self-assess their performance and have to find out information and I assess their competence and understanding. They have three observations of practice, for example bedrails. I check their understanding and observe them using these safely. All regular staff have annual updates which includes observations and practical. New staff do not support with any moving and handling until they are deemed competent. New staff now get a training buddy which wasn't happening but is now under the new manager. New staff do the care certificate." Staff also told us that they had yearly refresher training.

Staff told us the provider supported them to gain professional qualifications. One member of care staff told us the provider had supported them to complete their nursing degree. Supporting staff to develop means staff were able to maintain and improve their knowledge and skills.

People had mixed views on the quality of the food provided. Describing the quality of the food one person said, "The lamb was lovely, the best I have ever eaten." However, another person describing the food said, "Dreadful, cheap stuff. The cheapest bread they can find for breakfast, no quality about it whatsoever. They do ask me, usually after a meal and I'm quite honest with them. I tell them what I think, but no, it hasn't changed." Another person said, "I think the chef should be called the 'warmer-upper'. We have mince four times a week in various forms."

The quality of the food had been raised in the service quality assurance survey. We discussed people's concerns about the food with the management team. They told us that following the concerns from the quality assurance survey they had carried out a further survey to identify the issues. They had also carried out observations at meal times to assess the quality of the meal time experience. Following this the crockery and how tables were laid had been improved. A book had also been put on each floor for people to write their comments in about the food. The deputy manager told us that any comments in the books were reviewed at the daily management meeting. Kitchen staff also carried out observations at meal time to check the mealtime experience.

Staff had a good knowledge of people's dietary needs. When we asked one staff member what the needs were of people in the dining room we were observing they told us, "Some people are on thickened fluids and two people are on pureed diets and are assisted with meals. Three people are insulin dependent diabetics." Good staff knowledge of people's dietary needs reduced the risk of people receiving inappropriate food.

However, we did notice that there were chocolate snacks available on tables around the service. A relative expressed concerns about this saying, "[Relative] is diabetic. [Relative] is desperate for chocolate, when chocolates were put out [relative] ate them." This person was also living with dementia and was not able to make an informed decision as to whether it would be wise to eat chocolate. We raised this with one of the management team who thought that putting the chocolate out had only occurred at Christmas and was not now taking place. We showed them the chocolate on the tables which they removed.

We observed lunch in two of the dining rooms. There was a calm and relaxed atmosphere with staff sitting

and chatting with people or people chatting amongst themselves. Menu options were put onto small plates and shown to people so they could choose what they wanted. The kitchen assistant was observing the meal and talking to people to get feedback regarding the food and checking that menus were in place. Where people required support with their meal this was provided. Staff were seated directly adjacent to the person they were supporting, able to interact closely and appeared attentive and caring in their approach. One person required their food to be pureed. This was served in small ramekins and looked appetising. The person was able to eat independently due to the ramekins being small which aided their eating. We did note, on one floor, that the service of the meal was very slow which meant that some people were waiting some time before they received their food. However, when it was served it was hot.

Records we looked at did not always demonstrate that the service was maintaining effective oversight of people's fluid intake. One record we looked at gave the total fluid intake for the person but there was no information as to how this amount had been arrived at. The persons eating and drinking plan stated that if the person did not reach their fluid intake for three days the GP was to be informed. We were unable to see from the records if the person had reached their fluid intake each day. This was because the records were disorganised. There were three records for the same date, some records were not totalled and one was undated. We asked a senior member of staff if it had been necessary on any occasion to contact the GP. They told us that any action would be recorded on the person's daily notes. We could not see any action had been recorded. We were not assured that this person's hydration needs were being met.

The manager told us that people were supported to access healthcare professionals for example being supported by staff from Cavell Court on hospital visits. Where people required on going healthcare support with some specific conditions such as pressure ulcers care plans contained detailed instructions for changing the wound dressing. There was also information displayed in staff rooms reminding staff how to recognise the signs of dehydration and the management of choking.

People told us the environment met their needs. A relative said, "There is nothing within the environment to remind you that this is a care home. There are lovely areas, quiet lounges where we as a family could go. We call the ground floor reception our little living room." There was a coffee lounge area on the ground floor where people could meet and chat. During our inspection we saw a quiz being organised in this area. The colour scheme and decoration provided contrast between the walls and floor with prominent and regular handrails. Tables and high backed-chairs were positioned at regular intervals along the corridors. During our inspection we saw that specialist equipment had been used to support effective care delivery. For example, one person who had problems using the usual call bell had been given a larger call bell which they could use easier.

Requires Improvement

Is the service caring?

Our findings

Our inspection in May 2017 rated the service Good in Caring. At this inspection we found Caring to require improvement.

People told us that staff treated them with kindness, respect and compassion. One person said, "They [staff] are very polite and friendly, they were very helpful when I lost my [relative]. We think they are wonderful." A relative, referring to the attitude of staff told us, "The tenderness is just beyond belief, even the cleaner, really so lovely." Another relative said, "They [staff] know what makes [person] happy. They go out of their way to help them to become content, sometimes they're better at it than I am. I've seen nothing but professionalism. I don't hear bickering or negativity, positive conversation, apart from comments about being over worked and not being able to get breaks." However, the shortage of staff impacted on the ability of staff to support people's wellbeing in a caring and meaningful way and respond to their needs quickly. For example a relative had complained that when a person had rung their call bell a carer had attended, but had turned the call bell off saying they could not deal with the person straight away as they had two more people to deal with first. The person had needed to ring their call bell again after 30 minutes as nobody had returned.

Staff knew people's background and history and used this knowledge when providing care and support. One member of care staff said, "One lady is from Yorkshire and loves the accent. So I encourage her to talk by using the accent and developing a rapport and bringing her in some proper Yorkshire tea bags." We observed staff showing concern in a meaningful and caring manner. For example, when supporting people to position their wheelchairs at the dining room table they ensured they could reach the table and eat comfortably and if they wanted the footplates of their wheelchair removed.

People told us that when they moved into Cavell Court the service involved them in planning their care. One person told us, "[Named manager], their positivity got [person] here, they dealt with the care plan, involved me and [named person], not just their wellbeing, they dealt with life [background]. However, this involvement did not continue. For example, one person told us they had not had a bath or shower since September 2017. We checked their care plan which showed they had a daily body wash supported by staff. The person confirmed to us they would prefer a shower. Staff we spoke with confirmed that the person was able to have a shower but this had not been offered. The monthly review had not captured this person's preferences

People we spoke with told us that care staff were mindful of their privacy and dignity. The service had a dignity champion. They told us that their role involved promoting dignity across the team and addressing any practice that did not respect people's dignity. They gave examples of closing curtains and covering people with a towel when providing personal care. Another member of care staff said, "I always knock when I go in the room. When I assist with personal care I cover the person? with a towel and check that I have consent." We observed the daily management meeting and saw that staff who attended the meeting but did not need to be involved in the more personal and clinical discussions left the meeting before these took place. This ensured that personal information about people was treated confidentially.

People's rights to a family life were respected. Visitors were able to visit freely and were able to have meals with the person they were visiting. One person's relative told us that they had had lunch that day in the coffee lounge. However, they did tell us that they had had a long wait for lunch to be served.

The reception area was welcoming and had a coffee bar. We saw people enjoying spending time in this area with visitors during the day of our visit. Hot and cold drinks and a selection of snacks were available. There were items of interest from the provider, such as their vision and
values, newsletters, details of events that had taken place, the weekly activities programme and health information booklets that included.

Requires Improvement

Is the service responsive?

Our findings

Our inspection in May 2017 found that the service Required Improvement in this area. This was because care plans did not always contain sufficient detail. At this inspection we found that there was still room for improvement needed as not all care plans contained full details of the care and support people needed or reflected people's current needs.

The content of the care plans we looked at was inconsistent. Some care plans did not contain sufficient information and in others the information was not up to date. For example one person's care plan stated they had a catheter in place. We did not observe a catheter and confirmed with staff that this was no longer in place.

We also found that the information recorded in the care plan was not always being used to inform the care being provided by care staff. We observed an occasion where a person appeared to be falling out of their chair. We alerted care staff. The member of care staff said, "I don't know why [person] is in that one they can't sit back in it." We checked the person's care plan which detailed the type of chair they should be using.

The deputy manager told us that the service operated a resident of the day system. They explained that each month one person from each floor had their care plan reviewed, this included the risk assessments, a review of their care and if they were happy with the care provided over the previous months. It also included a review of activities the person had attended, a visit by the chef to check on any dietary changes and feedback about the food. They told us that this ensured that care plans were kept up to date and changes in people's needs or preferences recorded. However, care plans did not demonstrate that this method of review had been effective. There were deficiencies in care plans, as described above and they were not effective in ensuring that the care and support provided reflected people's preferences.

We asked a relative about the resident of the day system and if they had been involved in reviews. They replied, "Resident of the day means a deep clean of the room and a special menu. I am involved in [relatives] care and I was included when they did a review but I don't give them much choice to get it wrong as I am here six days a week." Another relative said they had only been involved in their relatives care review, "Once or twice in the last couple of years." They went on to say that they were not contacted by the service with information about when a review would be taking place.

Care plans we looked at contained information about people's personal history, individual preferences and interests. However, we found that the opportunity and support people got to socialise and carry on with interests varied across the service. One person described how when their relative was. "Downstairs," in the service they were, "Socially engaged." However, since the person had moved to a different floor they said, "There's just not the stimulation or activity to keep [relative] happy." Another relative said, "[Person] likes to listen to their radio in their room, but when I 'm not here it's easier for them [staff] to keep [person] in the social room [lounge] where staff can see them. A relative said, "Social activity is on the ground floor. Activities do happen but spasmodically. There is no leader for the team." Another relative gave us an example of equipment they had purchased so that a person could continue with an activity they had

enjoyed before moving into the service. They said that the equipment was now, "At the bottom of their wardrobe covered by a duvet," and expressed the view that it was not being used to provide meaningful activity. However, other people were positive about the support received to engage socially with one person saying, "They always try and involve you, on Monday I always go to the yoga class." Another person said, "All sorts of things take place like physical games, ball throwing and the parachute. There's almost too much to do for me."

There were notice boards around the service which provided people and their visitors with information about the activities taking place for the current week. There was a separate schedule for each floor. However, when asked about the advertised activities one relative said, "It is posted up on the walls about weekend activities but often they do not take place. The co-ordinators are weak. They lack drive and enthusiasm."

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

During our inspection we observed two members of staff organising a quiz in the reception area. They interacted well with people and guided them through the quiz asking questions and then prompting people to provide answers. This gradually developed into a more general conversation about people's interests and hobbies. We were also made aware that some people were going on an outing using the service mini bus. The venue for the outing was being assessed to ensure if was suitable following a severe weather warning. The manager told us that there were four members of staff employed full time to support people with activities and that there were activities staff at weekends.

People did not feel their concerns and complaints were listened to and responded to appropriately. One person describing the response when they raised a concern at a meeting said, "There are meetings, I've been to one but it was a bit of a disappointment, minor things. A staff member said to me, You're not the only one here. I got addressed like a school boy." This was not respectful to the person and did not encourage them to raise any future concerns. Another relative described how it had taken them over a week to speak with the deputy manager despite repeated requests via care staff.

Prior to our inspection we had concerns brought to our attention where the people felt that the service had not responded appropriately to their complaint. For one person who had raised a formal complaint in October 2017, this had not been resolved till January 2018. Whilst their complaint had been initially acknowledged by the service and they had been given a date for investigation and resolution, this time frame was not met by the provider. The person who had raised the complaint received no communication from the provider in the interim and it wasn't until two months after the expected conclusion date did they receive a response. A further two people reported that concerns had been raised with the manager at the service but that they were not acknowledged or responded to. They told us they lacked confidence in the provider in appropriately managing concerns and complaints with one person describing the approach as, 'A culture of excuse making.' This meant the provider had failed to adhere to their own complaint's policy.

We raised this with the management team during the inspection. They acknowledged that they were aware of some outstanding complaints which were now being dealt with by the operations support manager. The management team believed that much of the responsibility for deficiencies lay with a manager who was no longer working for the provider. They explained that the service had an electronic system for recording complaints. That this system was monitored by the central complaints team where the most up to date information was maintained and records of progress such as acknowledgement of the complaint and outcomes were recorded. It was expected that home managers would print complaints of the system for

ease of use as a backup. However, when we asked during our inspection for full details of individual complaints these had not been printed off. They were provided after the inspection.

These concerns represented a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to make decisions about their preferences for end of life care. This was included in people's care planning when they moved into the service. One person said, "[Staff member] asked [relative] what their plans were with death. They opened up the subject and got us talking about death. I was grateful for that, they they've written it in the care plan."

We spoke with a family who had recently suffered a bereavement in the service. They were extremely complimentary about the care and support provided both to the person and to the family. One family member said, "They were discreet, they explained to us how they would take care of everything. It helped us to understand, to grieve and be prepared."

Inadequate

Is the service well-led?

Our findings

Our inspection in May 2017 found that the service Required Improvement in this area. This was because the audits of care plans had not been effective and there were concerns around the management of medicines. At this inspection we have found that these concerns continued and had not been addressed.

Following our previous inspection we imposed conditions on the provider's registration regarding information they must provide us related to their management of medicines. The service had complied with these conditions. However, at this inspection we found continued concerns regarding medicines management. The service had independently identified further issues relevant to missed medicines. The provider had taken action to address the concerns which related to people not receiving their medicines when they should but concerns were still on going. On the day of our inspection some people were not getting their medicines as prescribed. Although the management were aware of concerns regarding medicines the overall management of medicines had not been effectively addressed.

Our previous inspection had also found inconsistencies in the quality of care plans. We were told at that inspection that plans for improvements were in place. At this inspection we have found that the quality of care plans was still inconsistent across the service. We discussed this with the management team who advised that some of the concerns about care plans appeared to be relevant to the resident of the day procedures. They told us that they would address this.

There are significant and widespread shortfalls amounting to five breaches of regulations contained in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service has been in breach of Regulation 12 and rated as requires improvement since it was first inspected in July 2016. Despite the CQC imposing conditions on the service registration they have failed to make and sustain improvements in medicine management. The service has failed to sustain the improvements found at the previous comprehensive inspection and are now in breach of the same regulations found in 2016. There is lack of proper oversight, leadership and governance at the service and the provider has repeatedly failed to cooperate with other agencies on safeguarding matters.

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

We discussed our concerns regarding the management and quality control at the service with the national operations support manager and the regional director. They told us that many of the concerns should have been addressed by the manager. That manager had not been registered with the CQC. They were not at the service on the first day of our inspection and we were told that they had resigned during the second day. The regional director told us that the person had gone through a robust recruitment process and they were disappointed that this had not been effective in ensuring the right person had been recruited to this registered manager position. The regional director told us that the provider had had concerns around the management of the service. The provider had put management support in to the service prior to our inspection to support the deputy manager. Actions had been taken to address shortfalls in the quality of the

service delivered. This included having a member of the management team on duty at weekends as it had been identified that more complaints were received at weekends. The service had also met with the agencies providing agency nurses to the service as they had identified that agency nurses were not providing the quality of care that the service required.

The service had systems in place to monitor the quality of care provided. These included regular audits which of care plans, accident and incident monitoring and monitoring of complaints. These audits then fed into the provider's computer system which was monitored to ensure incidents were dealt with appropriately and any trends were identified. An on going service improvement plan was in place which was monitored regularly by the provider. We discussed with the regional director why it appeared that these systems had not picked up the issues we had identified. They told us that the problems had arisen because of the deficiencies of the manager who had resigned.

Staff did not always feel that they were supported by the management team. One member of care staff said, "Managers need to be there for the staff and give them support but the managers keep changing which is a problem." Another member of care staff said, "I have been to a staff meeting, not really helpful. It was a lot of hot air and I didn't find it very productive." However, one member of care staff staid, "We have regular staff meetings and we can voice our opinions. There is an open door policy and the management are approachable and will listen."

We received mixed views from people, relatives and staff as to whether the service was well led. One person living in the service said, "It feels run all right to me." However, a relative said, "The management are down on staff, criticising rather than praising." Another relative said, "At one family meeting my relative commented about [member of management] in a bit of a critical fashion. Well the [other member of management] joined in the criticism and told the minute taker not to record what had been said." This did not demonstrate an open, transparent and honest culture within the service.

The service induction booklet for staff included the provider's vision and values. Staff knowledge of the vision and values was inconsistent. One senior member of staff said, "We want to be the best care provider in the UK, provide person centred care, work with families and involve them. However, another member of care staff said they did not know the vision and values of the service. Another said they had heard them but could not remember them.

The service had links with the local community who also came into the service to use some of the facilities. The service made its facilities, such us the cinema room, available to local community groups such as the mother and toddler group and bridge club. A member of staff told us that people living at the service were pleased to see the young children and also joined in with the bridge club.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care and support provided did not always meet people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed and administered safely. Risks to people were not always managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There was poor oversight, leadership and governance at the service

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient staff with the required skills and experieince to meet people's needs.