Mr & Mrs BN Patel

Cedars Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 6 and 28 July 2016 and was unannounced.

At our previous inspection on 25 and 26 June 2015 we found that the service required improvement and was rated Inadequate with regard to its safety. An action plan was submitted to the commission which stated that measures would be put in place to improve the service and ensure that people who used the service received safe and effective care. At this inspection we found that the required improvements had not all been put into place and our concerns about the safety and effectiveness of the service remained.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

The service provides accommodation for up to 63 people, some of whom are living with dementia. At the time of our inspection 57 people were resident. The service is split into two buildings which operate quite separately.

A registered manager was in post. 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.

Risks were assessed and documented in care plans but staff did not always manage risks effectively and people were not safe. The provider did not have oversight of the safety of the service and risks were not well monitored. We found that, in particular, risks related to scalding and infection control were not well managed. The service did not effectively manage risks related to the prevention of pressure sores for people with limited or no mobility.

Although people told us they felt there were sufficient staff on duty but we found there were not always enough staff to meet people's needs promptly. There was a lack of strategy in place regarding the deployment of staff. Staff recruitment was not robust.

Staff were trained in safeguarding people from abuse. However we found that some staff were not skilled in managing people's behaviour when they became distressed and this sometimes placed other service users at risk. The management of the service referred incidents appropriately to the local authority safeguarding team.

Medicines were managed safely. Staff were trained to administer medicines and their competence to do this was checked.

Established staff received the training they needed to carry out their roles but staff practice did not always demonstrate that they put this learning into place. New staff were not recruited robustly and did not always receive an effective induction which covered all the core skills they would need to carry out their role safely and effectively.

Staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The MCA ensures that people's capacity to consent to care and treatment is assessed. If people do not have the capacity to consent for themselves the appropriate professionals and relatives or legal representatives should be involved to ensure that decisions are taken in people's best interests according to a structured process. DoLS ensure that people are not unlawfully deprived of their liberty and where restrictions are required to protect people and keep them safe, this is done in line with legislation. The service did not always act accordance with the MCA and staff did not demonstrate an understanding of DoLS.

People who used the service praised the food and people were referred to dieticians if they required this. Support at mealtimes for people who needed help or encouragement to eat and maintain their weight was poor. Oversight of people's nutrition was poor and kitchen staff did not assure us that they had a good understanding of the principles of good nutrition for people living with dementia or diabetes.

Some staff were very caring and treated people respectfully, ensuring their dignity was maintained. However some staff showed a lack of patience and understanding of people's health conditions and did not respond appropriately or kindly to people's distress and anxiety.

Although most people, and their relatives, were happy with the level of involvement in planning and reviewing their care, some people did not feel they had been sufficiently involved.

People were not supported to follow a wide range of hobbies and interests. People living with dementia, and those unable to go out independently, lacked stimulation. Activities were provided on each of our inspection days to a small minority of people.

Formal and informal complaints were managed well and to people's satisfaction.

Staff understood their roles and felt they were well supported by the management team but showed a lack of accountability and responsibility in some cases.

Systems designed to assess and monitor the quality of the service were in place but were not always effective. The provider did not have a clear oversight of the issues affecting the service and did not

demonstrate strong leadership. The health and safety of the service was not adequately monitored and poor practice found at the last inspection, and which had placed people at risk, was still of concern at this inspection. The service was not clean and there were no clear procedures and processes related to the regular cleaning and monitoring of the service. The provider had not been proactive in establishing a robust recruitment and induction procedure for new staff.

We found several breaches of regulations during this inspection. You can see what action we have told the provider to take at the back of this report. We have also shared our concerns with the local authority contracts, quality and improvement, and environmental health teams.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The service was not clean throughout and there were no effective systems in place to limit and control the spread of infection.

Risks were assessed but staff did not always manage risks appropriately. Risks related to the environment had not been assessed and people were at potential risk of serious injury.

There were not enough staff and staff were not always deployed in a way which ensured people's needs were met promptly.

Staff were not robustly recruited.

Medicines were managed safely and staff competency to administer medicines checked.

Is the service effective?

Inadequate

The service was not effective.

The requirements of the law with regard to the MCA and DoLS had not been followed in all cases and staff understanding was poor.

Staff received training but their understanding of some aspects of care was not good. Induction for new staff was not effective.

People were positive about the food but those living with dementia or diabetes, did not get the specialist support and care they required.

People were promptly supported to access healthcare professionals when they needed to.

Is the service caring?

Requires Improvement

The service was not always caring.

Feedback from people who used the service and relatives was

positive about the kindness and patience of the staff but we observed that not all staff were caring and patient, although the majority were. People's dignity was not always maintained.

We observed good relationships between many staff and the people they were supporting and caring for.

People, or their relatives, were not always involved in making decisions about their care.

Is the service responsive?

Requires Improvement

The service was not responsive.

People, and their relatives, were not always involved in assessing and planning their care. Care plans, although detailed, were not always followed by staff and people's individual needs were not met.

There was a mixed picture regarding people following their own interests and hobbies. Some people were able to access the local community independently and were positive about the programme the service offered.

Person centred care for those living with dementia was poor and people lacked stimulation and occupation.

Complaints were managed well.

Is the service well-led?

Inadequate

The service was not well led.

People who used the service and staff were not actively involved in developing the service.

Although staff understood their roles and felt well supported by the management team, they did not always demonstrate accountability and responsibility. Communication with staff was ineffective and the provider did not routinely address poor practice with staff individually.

Audits designed to assess and monitor the quality and safety of the service were not effective and left people at risk of harm.

Cedars Residential Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 6 and 28 July 2016. Both inspections were unannounced.

The inspection team on 6 July consisted of one inspector, a pharmacist inspector, a specialist adviser who had expertise in pressure care and an expert-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 expert had experience of services for older people and of dementia care. On 28 July one inspector carried out the inspection.

Before we inspected we reviewed the information we held about the service. This included any statutory notifications that had been sent to us. A notification is information about important events which the service is required to send us by law.

We spoke with eight people who used the service, four relatives, one visiting professional, two domestic staff, the chef, twelve care staff (including three seniors), the deputy manager, the administrator and the registered manager. We observed staff providing care and support and we used the Short Observational framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not communicate with us easily. Following the inspection we also spoke with staff at the local authority environmental health department.

We reviewed nine care plans, 24 medication records, six staff recruitment files, staffing rotas for the ten weeks leading up to the inspection and records relating to the safety and maintenance of the service and its

equipment.

Inadequate

Is the service safe?

Our findings

At our last inspection on 25 and 26 June 2015 we found the service to have breached the regulations with regard to the safe management of medicines and with regard to risk assessment and management overall. At this inspection we found medicines management was much improved but we had continued concerns, some of which related to the same issues, regarding the management of other risks.

We saw that risks, such as those related to moving and handling, choking and a person's risk of falling, had been assessed and actions put in place to reduce these risks as much as possible. We were concerned that these risk assessments, although well written, were not well known by staff and actions were not always taken to effectively reduce risks for people. One member of staff who was the only member of staff for a period of time over lunch was not able to tell us if any of the ten people in the room were at risk of choking on their food. People's risk of developing a pressure sore was not reduced in all cases as actions stated in the risk assessment were not followed. On both inspection days we observed people sitting for several hours without a change of position. On 28 July we saw one person was seated in an armchair from 07.30, when they got out of bed, to 16.00 without a change of position or a change of incontinence pad. Staff were not able to tell us if, and when, this person had been repositioned.

We looked at the pressure relief charts for four people. They did not contain information for staff about how frequently people should be repositioned to reduce the risk of developing pressure sores and staff were unclear. Charts were sometimes left blank, or indicated that people had not been repositioned between getting up and going to bed. The registered manager had noted on 21 July 2016 in the communication book that staff had not been repositioning people during the day at all. Charts for the person we observed on 28 July 2016 showed that they had been left without staff attempting to reposition them at all during the day on 25, 26 and 27 July. We asked a senior member of staff how often this person should be repositioned and they told us this should happen once a day.

At our last inspection in June 2015 we observed that a garden hose was blocking a ramped pathway to the garden about ten centimetres from the ground. We asked the maintenance man to move it to ensure this did not present a trip hazard to people. At this inspection we found the hose being used in the same way. This demonstrated a disregard for the safety of people who used the service, some of whom had limited mobility. We also noted another person whose slippers were far too big for them and posed a trip hazard. We discussed this with the manager who told us that the family had brought these in. The manager did not demonstrate an understanding that they were ultimately responsible for the safety of this person.

We noted that incidents of distressed and anxious behaviour were not well managed by staff and people's actions sometimes placed others at risk. We observed one person knocking over a small table and trying to knock a chair over. Another person was walking by and was at risk of tripping over. Staff struggled to manage these incidents, especially as they were seen to be extremely busy carrying out other duties.

A small kitchen on Meadows unit contained a boiling water heater with a flip tap mechanism. The door was permanently propped open by a trolley and people living with dementia, whose bedrooms were on the

same corridor, had free access to the kitchen. There were no risk assessments related to the water heater. We also noted that carving knives were stored insecurely in this kitchen. The door had a lock fitted but the provider confirmed that they did not routinely lock this area. This again demonstrated a disregard for the safety of the people who used the service.

The service was not clean and there were no effective procedures in place to monitor the cleaning of the service. The staffroom carpet was black with dirt. The laundry was used to feed pets and contained pet food in several bowls which attracted flies.

We found that poor infection control placed people's health at risk. We noted that plastic pots, used to administer people's medicines, were washed up in the staffroom sink, which was dirty. There were no designated mops for bathrooms and toilets and the same mops were used throughout the service. Mops and buckets we saw were dirty and required replacing. We also found that toilet brushes required replacing and that some shower chairs were not clean underneath. Two people told us about separate occasions when they had noticed pools of urine and brought the matter to the attention of staff. In both cases staff did nothing and they had to chase the matter up with a second member of staff.

The main kitchen was not clean. There were cracked and dirty tiles on the walls; the microwave and toaster were not clean. The seal around the microwave door was not clean. We asked the chef about cleaning procedures and they told us they cleaned the kitchen thoroughly on a Thursday. We asked if the dishwasher was ever descaled but they were unable to tell us. The dishwasher was covered in stained lime scale which can harbour bacteria, including legionella bacteria. We also noted that in the fridge some foods were not covered and some were undated which meant we could not be sure they were safe to eat. The area marked 'ready to eat food only' was not kept clear and had used tea towels on it.

In the small kitchen on Meadows unit we found a milk dispenser machine which had mould growing on the inside. There was no procedure in place for the regular cleaning of this machine.

We also observed some poor practice from one member of staff with regard to infection control. We saw them wipe a person's mouth and eyes with their bare hands and then go on to help another person eat their lunch without washing their hands. Staff were overheard on two occasions saying that there were no gloves available.

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

There was a mixed picture with regard to the staffing levels at the service. Some people who used the service told us how quick the staff were to offer care and support. One person said, "Generally enough staff and always someone in the lounge". Another person said, "At night they come quickly". However most people had some level of concern, particularly about the mornings. One person said, "They are a bit rushed at times. They are short staffed first thing in the morning – sometimes they sit and chat when they are not rushed". Another person commented, "Not enough staff – mornings are busiest". One person was concerned about having to wait a long time to be supported to use the toilet. They told us, "The only problem is the wait for the toilet – longest wait is 15 minutes". Three relatives commented that staff sickness and annual leave can impact negatively on the level of care people receive.

Although call bells were answered promptly during our inspection, our observations were that there were also times when staff were not able to meet people's needs promptly and ensure their safety. There was also little evidence of a strategy related to the deployment of staff. For example we noted on both the days of our

inspection that over the lunchtime period in one part of the service, a new and inexperienced member of staff was left for lengthy periods of time to support several people who required prompting or active help to eat their meals. At the same time we noted seven members of staff were supporting people in the small dining room and small lounge next to it.

We carried out a structured observation over a lunchtime service and noted one person asking repeatedly to be taken to their bedroom. They continued to ask staff politely if they could go to their room from 11.54 until 12.25. Ultimately they became very distressed and angry and this had a negative impact on the other people who were trying to eat their lunch as well as the person themselves.

We saw that one person who used the service had recently moved in and was very anxious and demanding of staff time. Staff were having to provide one to one cover, even though this person was not funded for this. This had a negative impact on the level of care delivered to other people. There had been no review of staffing in the light of this person's arrival.

We looked at rotas for the ten weeks leading up to the inspection. These showed that sometimes the service had operated with less than their own assessed safe staffing levels. For example we noted that nine staff should be on the morning shift, but on the mornings of the 25 and 26 June there were only eight staff on duty. Only seven of the 55 people who used the service were described as 'self carers' which meant that 48 people required some level of staff support. Given that the service was split into two distinct buildings it was hard to see how these staffing levels ensured people's needs could be met promptly

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

Staff employed at the service had been through a recruitment process before they started work. Permanent and agency staff had checks in place from the Disclosure and Barring Service to establish if they had any criminal record which would exclude them from working in this setting. Other checks to establish if people were suitable were not robust. New staff had most often been telephoned, their availability, level of English and eligibility to work established and they were then employed. No structured interview took place to establish if they had the skills and competence to carry out the role. References were taken up, however we noted that in one staff file a reference supplied did not match the name given on the application form. The provider was not clear about who the referee was. Staff recruitment was not robust and did not ensure people were suitable for the position they were employed for.

This demonstrated a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that since our last inspection in June 2015 the provider had made improvements with regard to the storage and administration of medicines. Medicines, including controlled drugs, were stored securely, in a suitable environment, and were monitored appropriately.

We looked at records for 24 out of 57 residents and found that staff kept clear records of medicines administration. Records showed that people received medicines when they needed them, and there was guidance for staff on when to administer medicines intended to be given when needed, for example for pain or anxiety.

Staff received training in the administration of medicines and their competency was checked. We saw that when a member of staff forgot to sign a medicines administration record there was a process to check for

this and rectify it promptly. However when we asked about recording medicines incidents and errors to share learning and identify trends which might indicate the need for training or a change in practice, the provider was not able to give us any examples.

The provider carried out regular audits on medicines management. We saw an audit, conducted by an external pharmacist, which recommended that the provider update their medicines policy to reflect guidance from the National Institute for Health and Care Excellence (NICE), but they had not done this. The medicines policy was last reviewed in 2012, and we saw a copy of a covert administration policy last reviewed in 2009. These policies did not reflect current national guidance.

People told us they felt safe living in the service. One person told us, "People are safe – it's the efficiency of the staff". However some people were clearly uncomfortable as a result of the behaviour of other people who used the service. We observed two people spitting, shouting loudly and swearing at staff and other people who used the service and this clearly distressed some people. When one person, who had been shouting out all morning, was taken to use the toilet another person who used the service remarked to us, "Silence is golden. It's not often we get it in here". We found that staff did not always demonstrate sufficient concern about how these incidents affected other people who used the service.

Staff had received training in safeguarding people from abuse and systems were in place to try to reduce the risk of abuse but these were not always robust. Most staff were able to tell us what they would do if they suspected or witnessed abuse but some staff had limited English and we were not able to establish if they were clear on how to report concerns. However, we noted that staff did not lone work and there would always be other staff available to support them if there were any concerns. The service had reported safeguarding concerns appropriately and had notified CQC of any safeguarding concerns they were dealing with.

Inadequate

Is the service effective?

Our findings

Care plans contained assessments of people's capacity to make day to day decisions and we observed staff establishing people's consent. We also saw some poor staff practice. For example one member of staff went to assist a person to stand up using their walking frame. They spoke very loudly to the person saying, "Stand up please! Hold here! Hold here! Stand up! Stand up!" The person became upset and said ,"I can't – don't you understand that?". This staff member's English was limited and we observed a directness of tone from some staff for whom English was not their native tongue. We saw that this was perceived by some people negatively.

Do Not Attempt Resuscitation (DNAR) orders were in place for some people and had been filled out correctly. One relative told us, "I have had End of Life information from the home and we have a DNAR in place – they dealt with that well and [it] was discussed fully". However, although this part of the process had been completed appropriately, staff were not clear about people's wishes and could not tell us who had a DNAR in place.

MCA assessments and Best Interests decisions had been carried out appropriately to decide if people had the capacity to consent to receiving their medicines, or to give them their medicines covertly. Other decisions were not so well managed. One person, who the manager told us did not have capacity to make their own decisions, had been moved from a single to a shared room. This move was carried out as their mobility had decreased and the shared room was more suitable. No MCA assessment or Best Interests meeting had taken place. The deputy manager told us that the registered manager had discussed the matter with the person's next of kin but there was no evidence of this. The manager told us that they had informed the person's relative about the move. The provider had failed to ensure that this major decision in a person's life had been taken in their best interests.

Another person had bed rails in place. No MCA assessment had taken place and the deputy manager told us that the person had capacity to consent to 'some things'. No Best Interests meeting had taken place. The care plan stated that the matter had been discussed with the next of kin but again there was no evidence of this and no signatures. The registered manager told us that the hospital had insisted the service user had bedrails in place but no records confirmed this.

This was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff, including senior staff and the deputy manager, were not able to tell us who had a DoLS in place. One member of staff did not know what DoLS were. We observed staff putting a table in front of one person which prevented them from leaving their chair. The manager told us that 'a few' DoLS had been authorised and others had been applied for. We had not been notified to confirm anyone had a DoLS in place, although this is a requirement.

People who used the service, and their relatives, told us they were mostly happy with the way the staff team

supported and cared for them. People told us that the staff were well trained and they had confidence in their skills and abilities. One person said, "It is lovely here, marvellous staff who look after you. I cannot fault the staff". A relative praised the good communication from the service and commented , "[My relative] is very well cared for…[They] are well looked after". We observed that some staff demonstrated skills and expertise in supporting and caring for people. Staff spoke with us knowledgably about people's care needs and health conditions. However, some staff did not demonstrate this and we were concerned by their lack of basic caring skills which included rushing people when supporting them to move, leaving people's legs dangling off their chairs rather than adequately supporting them and making sure people's clothes were presentable.

When first employed we found that staff did not all undertake an induction which ensured they had the required skills and competences to carry out their role. We reviewed six staff files, four of which were for staff who had started work in the last year. Only one contained a structured induction which had been signed by the staff member and their mentor. Others either had no induction or had a first day checklist which covered basic information about day to day matters such as how to answer the telephone. Staff had a period of shadowing permanent staff but it was not clear how long this was supposed to be.

Staff, who had been employed on long term contracts through an agency, had been employed with minimal information known about them and had received no additional induction. We observed some of these staff carrying out their roles and saw that they did not have the required skills and experience. One person was supporting someone who had become clearly distressed. Their actions did not diffuse the anxiety but actually escalated it to a significant level. We noted that they had received no induction and had had no supervision sessions with their mentor since they started. This was a concern as their mentor told us they had identified that the staff member required additional support as they could become 'panicked'. Other staff had been provided with supervision sessions and some had been supported to undertake further national qualifications in care.

Staff received relevant training and we saw that a rolling programme was offered, although training in pressure care, nutrition, end of life and diabetes was not provided. We found that there was evidence that some people had not benefitted from the training that had been provided. We spoke with some staff whose standard of spoken English was so poor we could not establish what their understanding of the subject was. Their actions did not assure us that they had the required skills and knowledge to communicate effectively with the people who used the service or to meet their needs related to their dementia, diabetes, eating and drinking, infection control or pressure care.

This was in breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who use the service were mostly positive about the food and felt the chef made sure people were happy with the meals. One person told us, "The food is brilliant – I have eggs and bacon for breakfast. I am never hungry". Another person said, "If there is something you don't like you can ask for something else like an omelette". A third commented, "I am happy here – from all aspects it is the best care, environment and food". There was a choice of food each day. A relative of a person who used the service said, "There has been a huge change in [my relative's] eating and [they] now need help and I spoke with them today and they said 'we know we have to support [them]'".

We observed staff supporting people to choose and eat their meals. The lunchtime services we observed were task driven and for many people did not constitute a pleasant and sociable experience. We noted that while some staff ensured they explained to people what the meals were, sometimes showing them the two

options so they could decide, and supported them sensitively, others did not do this. We observed staff supporting several people to eat, moving from one to the other without speaking to them, and standing over them. People were not always given a choice of drink and we noted orange squash being given to all 24 people in one lounge and nobody was asked if they were happy with this. A relative told us, "Lots of carers are non-English and sometimes it is not clear and obvious what they are saying and when they ask [my relative] 'do you want tea or coffee?' some don't seem to know what [my relative] wants and they give [them] the wrong one. [They] prefer tea and not coffee".

We also saw that some people, who had been identified as being at risk of not eating or drinking enough, were not encouraged to eat or drink and their meals were left half finished or untouched. Some staff did not appear to have the skills to support people effectively to eat their meals and did not understand the importance of eating and drinking, both as a social activity and for good health.

We saw that one person, who had been identified as being at risk of not eating and drinking enough, was eating their food with their fingers. They were eating well. Two staff intervened and cleaned off their fingers which annoyed them to the extent that they pushed their meal away and the meal was eventually removed and no replacement offered. People were not given specially adapted cutlery and crockery to help them eat independently. We observed three further people, at risk of not eating enough, were not encouraged or supported to eat their food.

Finger foods were available to people but we found these were not always appetising. We saw that people had cut up roast potatoes and swede to eat. We asked the chef to tell us about finger foods and he told us that they give people things like roast cucumber, potatoes and swede. We noted plates of potatoes and swede stored in the fridge. We saw that one person's potatoes and swede, which we had seen them pushing away at lunchtime, had been saved in the fridge for supper. We asked the provider about this and suggested that alternative finger foods might be more suitable for this person but they were not able to think of any alternatives.

People's weights were well monitored and, when necessary, people were promptly referred to the dietician for advice and one had been recently discharged from the service as they had gained weight. Care plans documented people's particular needs and preferences however we were not assured that meals was always delivered in accordance with these. The chef was not able to tell us about how they catered for people's diabetes. They told us that they made low sugar jellies and low sugar packet desserts but did not talk about a good diet containing fresh vegetables or the importance of fluids and knowing about hidden sugars. We noted that one resident, who had a diagnosis of diabetes, had no care plan related to this and staff had no understanding that the poor management of this person's nutrition may have been linked to their extreme distress and confusion.

The chef's list of food preferences was not dated and the milkshakes list had not been updated since September 2015. Cream shots and milk shakes were provided for people who were of a low weight but records indicated this was not consistent. Food charts were not fully completed for some people which meant we could not gain an accurate picture about people's nutrition.

This was in breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed that people had access to a variety of healthcare services including GPs, district nurses, falls team, psychiatrists, opticians, dieticians and chiropodists. People told us staff responded quickly to their healthcare needs. One relative told us, "[My relative] has seen the GP and they arrange for someone to

come and do an eye test… they keep me informed". Records confirmed that people accessed relevant healthcare specialists quickly when they required this.

Staff were not always able to tell us about people's healthcare conditions and health needs. Staff were not able to tell us about what types of dementia people were suffering from. We asked six staff to tell us about one person's multiple health conditions. Only one staff member had read the care plan in sufficient detail to be able to tell us about all of this person's needs. Two staff were not able to tell us about any of this person's health needs, with one replying, "[They] just spit all the time. If you tell [them] it's not nice [they] done it anyway".

Requires Improvement

Is the service caring?

Our findings

People who use the service, and their relatives, were mostly happy with the way staff provided care and support. One person said, "In all ways they are kind and ask people if they are in pain – I see them laugh and joke". Another person told us "They are very caring and compassionate". A third commented, "Staff are always generous and kind – they have a lot to do for those who cannot walk". Relatives were mostly happy and praised the kindness of the staff.

We observed both very caring and less caring practice from the staff. We saw the activities co-ordinator spend a long time sitting and comforting a person who had become very distressed. They instinctively knew how to calm the person. They held their hand, chatted to them softly about their past and provided comfort. We noted that the person had been distressed all day and this was the only period of respite we noted for them. The activities co-ordinator had been intending to involve this person in an activity but realised this would make the person more anxious and so changed their plan.

Other staff had treated this person inflexibly and had not responded to their distress effectively. We noted that the person's care plan stated that staff should provide reassurance about the person's relative and chat about aspects of their past life. The activities co-ordinator was the only person we saw doing this on the day of our inspection, although two staff told us they had had similar conversations with the person previously. The person was constantly calling out a particular phrase but only one member of staff was able to tell us the significance of this. This meant that, despite the clear information in the person's care plan to guide staff, they remained distressed for much of the morning.

Care plans included information about people's life histories, including their family background, previous working life and friends who are important to them. We noted that these areas were blank in one person's care plan. Plans included people's choices and preferences. Some staff were able to tell us about people's past lives, their likes and dislikes in detail and we noted good relationships between these staff and the people they were supporting. Other staff, possibly due to limited English, were not able to tell us about people in any depth, although we did witness some caring interactions.

We received a mixed picture as to people's involvement in making decisions about their care. We saw that most care plans, which were reviewed monthly, had been shared with the person they concerned and these plans had been signed by them or their relatives if appropriate. A person who used the service told us, "[There's] a survey to fill in – part of your care plan and they ask if I agree what is happening and they record any health changes". Other people and relatives told us that there had been limited opportunities to be involved in reviewing their care plan. For example one relative said, "I have been asked about [their] likes and dislikes but not been involved a lot". Another relative commented, "I was involved at the beginning, 18 months ago".

Although some people felt they had not been sufficiently involved in a formal way in reviewing their care, most people felt that they were able to discuss their care, or that of their relative, with the staff, the deputy manager or the manager if they had a concern. One relative said, "There is always somebody you can go and

see".

Advocacy services were not routinely used by people at the service and we saw no information was available for people should they wish to consider the services of an advocate for themselves or their relative. We did not see a strong commitment by the service to provide information in formats which would be accessible to people. There were clear signs identifying the toilets and bathrooms but we saw that menus did not include pictures or photographs. People living with dementia were not routinely reminded of the food choice they had made earlier so some people may have been confused about what they were about to eat.

People's dignity was not always maintained. We saw a person walking around wearing ill-fitting jogging bottoms that were far too short and another person whose trousers were too loose and in danger of falling down. We observed staff speaking to one person as if to a child. They wanted to go back to their bedroom and repeatedly asked to be taken there, becoming more anxious and upset as time went on. Staff responded, "Have something to eat first" and "I will take you to bed. Finish your [pudding] and I will take you to bed" and finally, "Have your drink first". We also found the provision of bright coloured plastic plates and beakers for everyone, regardless of need, to be undignified.

Although the majority of staff provided care in a manner which maintained people's dignity and treated them with great respect, some did not. We saw that several people still had their aprons from breakfast on when lunchtime came around. We noted that a hoist was stored in one person's bedroom, even though they did not use the hoist themselves. Staff confirmed that this was the usual place for this equipment to be stored.

We heard language that was not always respectful. For example we asked about one person who was not eating their meal. A member of staff told us, "[They] are very difficult….[They] refuse. We can't help [them]. If [they] are not eating there is nothing we can do…We put it in front of [them] – if [they] eat, [they] eat". This showed a lack of respect for this person. We heard another staff member shout across the lounge, "How much urine output?" and their colleague responded, "Four". Again this was not respectful and did little to maintain the person's dignity.

We also found that written language was not always respectful. We saw that a bowel movement chart was divided into categories, one of which was 'mucky'. A person was describes as a 'fussy eater' in their care records. This is not professional or respectful language.

We noted that staff did not always respond to people's needs and left matters for others to attend to. For example one relative told us, "[My relative] had not been able to hear as the batteries in the hearing aid had gone and I left no spares – if I don't sort it out then it's not done". Another said, "Sometimes there is wee on the floor – their pads are not changed enough and two weeks ago I saw wee on the floor and mentioned it to a carer but had to retell another carer as [they] did nothing about it and the lady sat in wet clothing".

There were clear and detailed plans related to people's moving and handling needs. For example one person's plan identified that this should be done with two female carers and specified which sling size should be used. We witnessed staff carrying out moving and handling in a sensitive manner, providing reassurance. However we also witnessed one occasion where a person was shouting 'No, no, no!" and staff ignored them and carried on hoisting them without any reassurance or explanation.

This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service worked with other healthcare professionals such as district nurses to support people at the end of their life. People's particular wishes had been recorded in their care plans and relatives involved, if appropriate. Staff , including senior staff, had not received specific end of life training and this was not planned.

Requires Improvement

Is the service responsive?

Our findings

We saw that people's care and support needs were assessed before they moved into the service and a care plan drawn up once they moved in. We noted that one person had recently had a short stay in hospital and their care plan had been completely reviewed on their return to the service. Their risk assessments had been updated and reflected their current needs.

People who were seen to be more independent were satisfied with their care and felt that staff responded well to their needs and listened to them. One person said, "I get up between 6 and 6.30. I get up when I want and get myself washed and dressed, come here for breakfast. I don't need help… I have lunch and tea in my chair…. my choice". Another commented, "I do the Telegraph crossword every day and my knitting. I had communion today when they came and I go to the town for lunch. I go to the dining room for meals and sometimes I walk in the garden… I choose my own clothes but sometimes they help me match them up".

People who used the service, or their relatives, had mostly been involved in developing their care plans and plans reflected how people wished to receive their care and support. We found that plans included detailed guidance about how to support and care for people and they were regularly reviewed by the manager.

The concern that we identified was that staff were not always carrying out their roles in accordance with people's plans and the provider appeared to have little oversight of this. For example people were asked about their preferences for baths or showers and this was noted in their care plans. One relative told us, "I am not convinced that they bath or shower them enough, sometimes the residents smell"

There was a bathing rota in operation and records were kept of when people had baths or showers. We looked at these records for the period of 26 June to 6 July. The 24 people who lived in Meadows had all been given bed baths during this period. Records for the 33 people living in the other part of the service showed only eight occasions when people had been given a bath or shower. Five people were described as 'self-carers' which meant they could bathe independently.

Staff, including senior staff and the deputy manager, were not able to tell us who had a Do Not Attempt Resuscitation order in place. We asked two senior staff and the deputy manager and they were not certain. Staff told us they would go and find the care plan but these were not always located easily and were not kept securely. This could mean a delay in establishing the correct action to take in an emergency.

One person who had recently moved to the service was observed to be upset and distressed. They were calling out and were clearly very confused about their new situation. Staff supporting this person were not all able to tell us about this person's family, where they had been before coming to the service or what their health conditions were. The care plan identified most of this information and the manager had put a handwritten note in the communication book to help guide staff but not all staff supporting them were clear and did not put the suggested strategies in place to calm the person's anxiety.

The service did not provide person centred care for people living with dementia. The environment was not

suitable and we noted that both the radio and television were often on at the same time. Only three seats were facing the television in one lounge which meant that the other 21 people, who regularly used the lounge, could not even see it but would have been affected by the noise. There were no reminiscence activities available to engage people throughout the day and no sensory equipment. We noted several people fiddling with their clothing and asked a senior member of staff if there was anything people could be given, such as a range of differently textured fabrics. They told us, "The activities ladies do this" but we did not observe this and it was not clear why care staff did not offer this.

This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The activities staff member worked four days during the week only. We saw that there was nobody designated to cover this role on Fridays or the weekend or when the activities staff member was on leave. We observed the activities staff member carrying out a group activity making a birthday card with four people and playing ball with two other people. One person told us, "She asks if I want to do jigsaws. They do other things to activate minds. She takes people out into the garden". A relative said, "They do bingo, question and answer memory games with cards, puzzles, they make cards".

People who were more independent were able to access the community and we saw people accessing the local town. One person told us, " They take me out if they pop into town. I do my sketching, get up and go to bed when I want. I am definitely as independent as I can be. They will let me walk into town if I want but I like the company". Another similarly independent person said, "I go to town to change my library books and usually walk in and bus back".

The experience for those people who required more support was less fulfilling. There was no structured one to one time for anyone, although we did see a couple of people receiving some individual attention. We noted, on both days, that people spent the vast majority of their time sitting and waiting either for the next meal or to receive personal care. Most people simply had no daytime activity and there was nothing to entertain them on either day except television and this was often put on with no consultation with people. Staff had very limited time to sit and chat to people as they were very busy and the limited English language skills of some staff were an additional issue.

Handovers provided information for staff on the next shift. We found that some handover notes were detailed and clear and drew staff attention to particular concerns such as a person's skin appearing quite red or a person needing additional drinks as they had not drunk much in the morning. Other notes were brief and sometimes not wholly accurate. For example, we saw that one person had been described as being 'ok' when in fact they had been consistently distressed all morning. One staff member was late for the handover meeting and following this was not able to tell us if one person had received a change of incontinence pad or a change of position. They told us, "The morning staff would have done that" when in fact they had not.

After the inspection the service sent us minutes from meetings held for people who use the service. However, we saw no evidence that relatives had been invited to attend to give their views or to support people living with dementia. One relative commented, "No, my views are not asked for". Relatives were invited, if appropriate, to the annual review of people's care. One person commented, "No resident meetings but most have dementia- they give out a survey for us to fill in."

Annual surveys had been sent to relatives for them to complete with their family member. The results were analysed by the manager. We saw that issues highlighted in the most recent survey had been taken forward.

We noted that the response rate for the surveys was 21 out of a current total of 57 people resident. This left a large proportion of people who used the service who had not been supported to express their views in this way. We could not see how the service was proactive abut seeking out the views of those less able to communicate with them or those whose family did not advocate for them.

The service had a complaints procedure and people, and their relatives, were aware of it. The service had received two formal complaints since our last inspection and we saw that these had been responded to in writing and had been resolved to people's satisfaction. One person explained, "If there is something you object to or don't like you can speak to Mrs Patel and it is fixed. One staff member kept coming into my room and saying' Are you awake?' and putting the light on. I spoke to Mrs Patel and it stopped".

Inadequate

Is the service well-led?

Our findings

Most people who used the service, their relatives, and the staff said they found the management team approachable. There was much praise for the manager with many people commenting on how approachable she is. One person who used the service said, "It is well managed as far as I know. Mrs Patel comes round every morning and says good morning and asks how you are…. I have confidence in the manager and I can knock on her door and go and speak about anything". Another person said, "The manager is brilliant – definitely able to talk to her". A relative commented, "I like the manager and get on well with her. As far as I can see it is well run and I can speak to her anytime".

Staff told us they felt well supported by the manager and deputy manager. Staff meetings took place but they did not document who attended and did not indicate that the meetings had been an opportunity for staff to provide feedback and discuss current issues within the service. Minutes outlined a number of issues which indicated that there were some poor staff practices within the service. For example the meeting held 12 May 2016 minuted the following points: Working efficiently – time management; Staff behaviour in front of resident i.e. not shouting; Speaking in English only when at work. There was no additional information and it was not clear why these issues had not resulted in supervision or disciplinary action for the staff member concerned rather than general inclusion in a staff meeting.

Many of the issues we identified at this inspection were also noted in this staff meeting which showed that the provider was aware of some poor practice and need for improvements. This was the case with regard to the issues noted above and also pressure care, being present for handovers, bathing people appropriately, not putting tables in front of people to restrict their movement, dealing with residents when they were distressed, promoting food and fluids to those at risk of not eating and drinking enough and accurate record keeping. However, although identified as issues by the provider, the monitoring of these issues and overall oversight was poor. The systems used by the provider had not driven improvement in these areas as they still remained an ongoing concern and identified by CQC as impacting negatively on people who used the service.

The manager carried out an audit of medication, falls and accidents and we saw that trends were analysed. For example one person had sustained three falls in the week of the inspection and had been referred to the falls team again for further advice. However, we saw no such oversight for infection control, health and safety, cleaning and for the provision of basic care, especially for those living with dementia. The manager had clearly written detailed care plans to guide staff but they were not sufficiently aware of the fact that staff were not all delivering an acceptable standard of care throughout the service. Aside from one disciplinary measure, the provider had taken no action with regard to any member of staff's poor or unsafe practice even though they were aware of some incidences of this. When we raised this issue the provider asked, "How do you get them to listen?" This brings into question the manager's ability to demonstrate good management and leadership skills. There was not adequate responsibility and accountability seen at all levels of staff. Staff were not suitably motivated and supported to achieve this.

We questioned the judgement of employing people with limited or no care experience and limited English

and then failing to adequately support and supervise them. It was not acceptable to find staff without the required skills and experience working without close supervision, caring for people with complex and demanding needs. When we asked the administrator about the poor English skills of one member of staff they told us that the person was employed on the understanding that they took English lessons but this was not recorded in their staff file and they had not taken any lessons since their employment commenced.

Systems for recruiting new staff were not always robust and there was no effective strategy regarding staffing levels and the deployment of staff, especially around the lunchtime period. Although there was an overall training matrix and people's training was kept under review we found that no thought had been given to specialist training to help staff support people with their diabetes, pressure care, nutrition or end of life care. The service had no champions for infection control, dementia or nutrition for example. Champions are people who are provided with additional training and expertise which is then cascaded down to the rest of the staff team. We found no evidence for how the manager was moving the service forward and focussing on ways to constantly improve. There was no service improvement plan and they did not link to any local networks to ensure they were updated on new information and legislation related to adult social care.

People's care records were stored in the staff room and a corridor in unlocked cabinets which meant people could not be fully assured that their personal information remained confidential. This point was made at our last inspection and had not been addressed. People have a right to have their private information stored securely. As noted elsewhere in this report records related to the administration of medicines and food and fluid charts and repositioning charts were not always complete. Staff records were not always well organised and some were incomplete

This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our overall impression of the service was that people who were reasonably independent had an acceptable quality of life and were satisfied with their care. Those with considerably higher care needs were seen to spend most of their time waiting for the next meal or cup of tea or to go back to bed. There was little stimulation and staff, although clearly busy, were often task driven in their approach. This impacted on the dignity of people using the service.