HC-One Limited

Cedar House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Cedar House offers accommodation and personal or nursing care for up to 42 older people, some of whom are living with dementia. Accommodation is provided on the ground and first floor of a purpose-built building. There were 32 people using the service at the time of our inspection, two of whom were in hospital.

Cedar House is part of HC-One Oval Limited, a large organisation which owns over 300 care homes across the United Kingdom.

People's experience of using this service and what we found

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Risk assessments and support plans were in place to help staff to deliver safe care to people. However, staff did not always follow these and we witnessed unsafe practices which put people at risk of avoidable harm. People received their medicines as prescribed. However, staff did not follow the provider's medicines policy in relation to medicines to be given 'as required', and medicines which were given covertly.

People were not always protected from the risk of infection and cross contamination. On the day of our inspection, there was a malodour which persisted throughout the day. Staff did not always follow the provider's health and safety and fire policy and procedures and there were significant safety risks identified during our inspection.

People were not treated in a kind and dignified manner all the time. The staff worked in a task-focussed manner and did not always meet people's needs or consult them in relation to what they wanted to do. Staff were not always aware of their needs. People's communication needs were not always met.

The provider's quality monitoring systems were inadequate as, although they had identified many of the shortfalls we found during our inspection several months ago, we found the service failed to demonstrate they were providing care and support that was safe, caring, effective or responsive. This put people at risk of harm.

There were few activities taking place on the day of our inspection, and the activities on offer did not meet people's needs. The environment and the activities had not been developed to meet the needs of people living with dementia.

People's nutritional needs were not always met and mealtime was not always a positive experience for people who used the service.

Care plans were developed from the initial assessments and contained enough information for staff to know how to meet people's needs. However, staff did not always support people in line with their care plans.

Staff received training and had a basic knowledge of the principles of the MCA. However, they did not always consult people or give them choice. They did not always use the least restrictive options when supporting people.

The provider had recruited more staff to help ensure there were sufficient staff to meet people's needs. Incidents and accidents were recorded and there were systems in place to learn from these to prevent the risk of reoccurrence.

People's healthcare needs were recorded and met.

Staff received regular supervision and an annual appraisal. New staff received an induction and relevant training to help ensure they could provide effective care.

The service worked with other health and social care professionals who spoke well of them.

Rating at last inspection (and update)
The last rating for this service was requires improvement (published 10 April 2019) and there were two breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified breaches in relation to safe care and treatment, need for consent, person-centred care, dignity and respect and good governance at this inspection.
We made a recommendation in relation to the environment.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service.

This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Cedar House

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by two inspectors, a member of the CQC's medicines team 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.

Service and service type
Cedar House 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key

information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with 14 people who used the service and four relatives about their experience of the care provided. We spoke with eleven members of staff including the area director, registered manager, clinical lead, nurses, care workers and the chef. 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 talk with us.

We reviewed a range of records. This included eight people's care records and multiple medicines records. We looked at five staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We contacted six professionals who regularly visit the service and received a reply from two.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate.

This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management;
● Risks to people's safety and wellbeing were assessed and recorded, and there were guidelines for staff. However, on the day of our inspection, we witnessed staff did not always follow these and support people safely, putting them at risk of avoidable harm.
● We saw staff supporting a person to transfer from their armchair to a wheelchair. They did not put the wheelchair's brakes on and did not support the person to position themselves safely before being transferred. This meant the person felt unsafe and was showing signs of distress. Although staff were reassuring them, they only noticed the brakes were not on when the person was half sitting on the chair.
● One person was attempting to stand up from their wheelchair. The foot plates of the wheelchair were down, and the person nearly tripped over these as they stood up. One of the person's slipper got caught on the foot plates and came off. The staff member looked at the slipper and kicked it under the table. The person walked around with one slipper on for at least the next 20 minutes.
● One person was at risk of rolling out of bed and sustaining injuries. The risk assessment included measures in place to reduce the risk and these were in place. For example, a sensor mat was on the floor so staff would be alerted should the person get up unaided. However, we noticed that the person's feet were out of the bed and touching the mat, and this had not triggered the alarm. We raised this with staff who confirmed this did not seem to be working. We discussed this with the registered manager who checked and found the mat was not plugged in properly. This meant the person could have fallen out of bed and staff would not have been alerted.
● During the morning, the fire alarm went off and a fault was found on the fire panel, which prevented the system from being reset. This meant the codes to the doors were no longer working and there was a risk people may go out unsupervised. Whilst the registered manager took prompt action to ensure staff were positioned near the doors leading to outside, they had not secured the internal doors leading to the stairs. There were no signs to deter people from accessing the area, and we found a vacuum cleaner lead running the full length of the stairs. This posed a trip hazard to people and others using the stairs.
● We found a tub of thickener on top of a cupboard which had not been locked away after lunch. Thickeners are used to make all liquids, including beverages and soups, a thicker consistency that is less likely to cause people to choke. However, if misused can be dangerous and therefore should be secured where it could not be accessed.

The provider had not ensured that all reasonably practicable steps were taken to mitigate risks to people and to follow good practice guidance to make sure the risk was as low as is reasonably possible to people. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008(Regulated

Activities) Regulations 2014.

Preventing and controlling infection

● People were not always protected from the risk of infection and cross contamination. At our last inspection, we made a recommendation in relation to infection control because people who required the use of hoists to mobilise did not have their own allocated slings and there was a risk of cross contamination. We also found there was a strong malodour in areas of the home. At this inspection, we saw people had been provided with their own slings, the provider had a cleaning programme in place which included the cleaning of equipment and undertook regular infection control audits. Actions from the audits were reflected in the provider's improvement plan. However, there was still a strong malodour in areas of the home which we found throughout the day.

● In some of the lounges, there was a smell of faeces. Staff did not seem to notice this. We did not see people being consulted or supported with personal care during our observations and when people were being assisted from the lounge to the dining room.

● Some of the furniture was unclean and marked. In one of the bedrooms, the person's armchair was greasy. A bathroom on the first floor did not store any personal protective equipment (PPE) for staff to use. The drawer labelled for PPE contained someone's medicated cream. The commode shower chair contained a liquid, and this was not emptied all day.

● Before, and throughout lunch service, staff kept coming in and out of the room. To start with they needed to keep opening the door because it kept shutting (due to the problem with the fire alarm system). There was no hand sanitiser in the room, so whenever they came in and out they were not following best hand hygiene practice.

● None of the people using the service were given the opportunity to wash their hands and there were no wipes offered. There were no obvious tissues in the room and at one point a person wiped their face and nose on the table cloth. None of the staff did anything about this. One person dropped their serviette on the floor. The staff picked this up and gave it back to them. They were not offered a new one. One person dropped their cutlery on the floor. No one picked this up for the duration of the meal.

The provider had failed to protect people from the risk of infection and cross contamination. This is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

● There were regular safety and fire checks undertaken and people had personal emergency evacuation plans in place.

Using medicines safely

● People did not always receive their medicines safely and as prescribed. There was a medicines policy in place. However, staff did not always follow this. Care plans for medicines did not always have adequate information related to prescribed medicines. This meant there was a risk staff may not be able support people's medical and health needs effectively.

● Some people were being given medicines covertly. The staff had not always consulted the pharmacist to gain advice, for example, if the medicines could be given by mixing with food. Also, for one person the pharmacist and GP had not been consulted before giving medicines covertly. Covert administration is when medicines are given to a person without his/her knowledge and often disguised in food or drink.

● Some people were prescribed medicines to be taken when required (PRN). Guidance in the form of PRN protocols were not always in place or person centred to help staff give these medicines consistently.

● The provider carried out internal medicines audits. However, these had failed to identify the concerns relating to medicines management we found during our inspection.

The provider had not always ensured people received their medicines safely and as prescribed. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

● We observed staff give medicines to people in the morning and afternoon. The staff were polite and gained permission before giving medicines to people. They signed for each medicine on the Medicines Administration Record (MAR) after giving it.
● Medicines including controlled drugs (CDs) were stored securely. A controlled substance is generally a drug or chemical whose manufacture, possession, or use is regulated by a government. Staff monitored and recorded medicines refrigerator and room temperatures daily. These were within the required range.

Staffing and recruitment
● Most people and relatives we spoke with thought the staffing levels had improved since the last inspection. One person told us, "We're getting more regular carers now" and another said they felt safe and there was enough staff. However, one relative stated, "At the weekend they can be short of staff. It can be a bit chaotic. They are late getting people up."
● The registered manager confirmed they had employed new staff including senior staff and this had enabled them to reduce the use of agency (temporary) staff. However, they still relied on agency staff in the event of staff sickness and for people who required one to one support.
● The provider used a dependency tool to help establish the number of care staff needed to meet the needs of people who used the service. People assessed to have high needs were allocated one to one support. This was in place for two people on the day of our inspection.
● Staffing records indicated the provider carried out checks on staff before they supported people to help ensure they were suitable. Records included an application form, references from previous employers, proof of identity and the right to work in the United Kingdom and criminal records check.

Systems and processes to safeguard people from the risk of abuse
● There was a safeguarding policy and procedures in place and staff were aware of these. The provider sent notifications to the local authority when there was a safeguarding concern and worked with them to investigate and put systems in place for the protection of people who used the service. Staff received training in safeguarding adults and understood how to report abuse.

Learning lessons when things go wrong
● There was a policy and procedures for managing accidents and incidents. The provider kept a log of all accidents and incidents. Accident and incident records included details of what happened, date and time, and action taken. However, we could not see evidence of specific learning recorded in relation to how to prevent reoccurrence.
● We discussed this with the registered manager who assured us they carried out a root cause analysis (RCA) for all serious incidents and discussed their findings with staff so they could reflect on what happened and how to prevent reoccurrence. We saw evidence of this in relation to a person who had sustained an unexplained fracture. The RCA was signed by all staff to evidence they had understood and agreed the action plan.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

At our last inspection the provider had not always ensured people using the service received support to eat and drink or to choose their meals according to their preferences. This was a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 14. However, further improvements were needed to make sure people were offered choice.

- People's opinion of the food on offer varied. Their comments included, "The food is not too bad at the moment", "The food is good" and "The food could be improved." From our observations, we found people did not always receive the support they needed to enjoy mealtimes.
- Staff offered people drinks but did not give them a choice of these. One staff member offered one of the inspection team a cup of tea. They declined but a person who used the service stated they would like one. They were told lunch would be ready soon.
- People were offered two choices of meals and where people did not eat any of the two options, alternative meals were provided, including a vegetarian option where this was people's preferences. There was, however, no choice of meals for people who needed their food pureed. The provider told us that HC-One menus had received an award for excellence and were 'Vegetarian for Life' accredited.
- No one was offered condiments or salt or pepper, although one person was offered gravy which was poured on their meal in front of them.
- The menu was set by HC-One Ltd. The chefs did not seek feedback from people after their meals about whether they enjoyed their meals. They told us they relied on a dietary information sheet written by the nurses. However, they met people individually as part of the 'resident of the day' initiative to discuss meal options and preferences.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

● Staff received training in the principles of the MCA and displayed some basic understanding of these, however, from our observations, the staff did not always give people choice, consult them or consider the least restrictive options.

● We saw one person being offered a pureed meal although this was not part of their care plan. We asked a staff member about this. They told us they were on a pureed meal because they spat out the meat. There was no evidence of this issue recorded in the person's care plan.

● The same staff member stated the person was 'a slow eater' and this was the reason they were on puree. This was also said to the registered manager in the corridor after lunch, who accepted this explanation.

● One person ate their meal independently, then put their knife and fork down, indicating they had eaten enough. A member of staff then proceeded to assist them and made them eat the rest of their meal. This was not discussed with the person. Furthermore, the staff did not try any less restrictive technique beforehand such as asking if they would try a bit more or talking about it.

● Staff did not always consult the GP or the pharmacist before giving people's medicines covertly.

People who used the service were not always consulted and consent was not always obtained before providing care and support. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's mental capacity was assessed before they began to use the service, and we saw evidence of mental capacity assessments in people's files. The provider understood their responsibilities under the MCA. Where necessary, they had made applications to the local authority for authorisations to deprive people of their liberty in order to keep them safe. At the time of our inspection, nobody was being deprived of their liberty unlawfully.

Adapting service, design, decoration to meet people's needs

● There were some features designed to meet the needs of people with dementia. For example, a 'garden corner' with artificial grass, a bench and plants, and some hats on pegs. There were memory boxes outside people's bedrooms but these were not always personalised as several people had the same object, such as a bingo card and some were empty.

● There was some signage to help people orient themselves around the home. However, doors and corridors were similar looking and there were no names or features to identify bedrooms.

● Lounges were largely bare of features, with the exception of a 'sensory' style room with lights on the first floor. People's bedrooms varied but some were empty of personal features, pictures or ornaments. We found where people who did not have family support, there was limited evidence staff had tried to make their rooms homely.

● A notice board displayed a mix of information for staff, visitors and people who used the service. This

made it difficult for people to identify information meant for them, such as the activity planner. There were no menus on tables and the menu displayed on the first floor outside the dining room was for a different day.

We recommend that the provider seeks relevant guidance in relation to developing the environment to meet the needs of people living with dementia.

● Some improvements were taking place in relation to the environment on the day of our inspection. The provider was in the process of redecorating a lounge on the ground floor and they intended to make this room more attractive and welcoming.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's care and support needs were assessed prior to being admitted to the home, to help ensure staff could meet their needs. Pre-admission assessment were comprehensive and included people's likes and dislikes and how they wanted their care provided. This information was used to create care and support plans.

Staff support: induction, training, skills and experience
● People were supported by staff who received training, were supervised and appraised. However, we found some training was overdue, and this had been identified by the area director during an internal inspection. The provider's action plan stated they planned to make the improvement in this area. We saw where staff had not renewed training which was due, the provider wrote to them inviting them to a meeting to investigate the reason for this.
● Staff told us they received a good induction before they started to work for the service. One staff member stated, "I was in admin before and this is my first care job. They gave me a really useful induction and training." Staff were expected to complete the Care Certificate. The Care Certificate is a nationally recognised set of standards that gives new staff to care an introduction to their roles and responsibilities.
● Staff received training in subjects the provider identified as mandatory. This included safeguarding adults, health and safety, infection control, moving and handling and medicines. They also received training specific to the needs of the people who used the service, such as falls awareness, nutrition and hydration and caring for people with dementia.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People's healthcare needs were recorded in their care plans. Where people had specific needs, these were recorded and included guidelines to staff to help them meet the person's needs. For example, where a person lived with diabetes, we saw they had an up to date 'diabetes support plan' in place. This included the type of diabetes, treatment prescribed, contact details of the medical professionals involved in the person's care and how to monitor the person's blood glucose. It also included signs and symptoms for staff to look out for, and to inform them if the person was becoming unwell.
● People were supported to access healthcare professionals and to attend appointments where needed. We saw evidence of healthcare professionals visiting regularly and recording the purpose of their visits and outcome. People's care records contained a variety of letters from different healthcare agencies, where people had attended. For example, hospital appointments.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate.

This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported

● People were not always treated with kindness and compassion by staff when they supported them, as their approach was task focussed. The majority of staff did not show affection for people who used the service or indicate they liked them or could see from their perspective.

● One staff member told us they liked working at the service and thought people were interesting. However, they added, "Care is not as bad as you think it will be. You have to change people and I thought I would really hate that but it is ok." They showed no concept of how it might feel for the person being changed.

● We observed care and support on both floors during the morning. In one of the lounges, the television was on. People were showing no interest in the program, but the staff were watching this. Shortly after this the fire alarm went off and all the doors closed. One person woke up and said, ''Not again this happened yesterday.'' Staff went to the assembly point. Nobody offered reassurance or explained why the fire alarm went off.

● A member of staff came in with the tea trolley, sighing loudly. They put some biscuits on a plate using their hand, and poured a drink for a person saying, ''Here you go [Person], a cup of tea.'' The person then said, ''I wish I could find my cardigan'', but the staff member did not respond.

● As people were bought to the dining room for lunch, most staff were polite and asked them if they would like to sit down. However, we heard one staff member tell a person to, ''Come and sit your bum over here.'' Later they called across the room to other staff, and repeated twice, ''[Person] has conked out in [their] chair.'' The same staff member called out to a person to ask how their 'itch' was.

● One person was attempting to walk around but was constantly told to sit down. One staff member said, ''Where do you want to go? Do you want to sit down.'' The staff member then took them by the arm and lowered them into any armchair. The staff member then sat down next to the person and watched the television.

● The person got up on numerous occasions and was either told to sit down again, or the staff member blocked their way. We heard the staff member say, ''Come on'' and pointing to the chair, ''Sit down, here and down.'' They then lowered the person by the arm and placed them in the chair, saying, "Here is a drink."

● We saw a member of staff move a person's wheelchair from behind without warning or explanation to the person.

Supporting people to express their views and be involved in making decisions about their care;

● Care plans stated people's preferences for the gender of their care workers. However, we could not be sure

this always reflected their choice. For example, one person's care plan stated they had no preference but also showed they could not express this kind of choice. There were no records of consultation with relatives or best interests decision. On the day of our inspection, the person had one to one support from a member of staff of the opposite sex.

Respecting equality and diversity

● The provider had an equality and diversity policy in place. However, care records did not contain information about people's needs in relation to their sexuality so staff could support those who may have specific needs in this area. At the time of our inspection, the registered manager told us they did not support people from the lesbian, gay, bisexual and transgender (LGBT+) community. The registered manager was unaware of current guidance and had not taken any action to promote an inclusive environment.

● People were not always called by their preferred name. The registered manager told us specifically that a person preferred their shortened name to be used. However, throughout the day, staff did not respect this and were referring to them as their full name.

Respecting and promoting people's privacy, dignity and independence

● Some staff spoke to people in an inappropriate manner and did not always respect their privacy. For example, one person stood up and walked to the door. A member of staff said, ''Are you alright, do you need the toilet?'' When the person replied they did not, the staff replied, ''Where are you going then?'' The staff member then came back almost immediately and sat down to watch the television again. Another person said, ''I don't know if you are coming or going today.'' No one responded.

● Staff were distracted and did not support people with respect during their meal. Two people required support with eating. One staff member spent some time standing instead of sitting and constantly talking to another staff member about the person they were supporting. There was no concept of privacy around this. They also mixed up the person's food absentmindedly whilst waiting between mouthfuls. Half way through the meal, they went off somewhere and someone carried on supporting the person.

● We saw another staff interacting with a person whilst supporting them to eat. However, when the staff in the room were discussing who was going to support another person, the staff member said, "I can finish here and go." Not only were they ignoring the person they were supporting by talking to the other staff, their choice of words was disrespectful.

● The staff did not always communicate well between them and this meant people's needs were not always met during lunch. The staff asked everyone if they wanted to wear aprons before they placed them on people. One staff said to a person, ''You don't like these do you, so I am just going to leave it here on the table in case you need it.'' However, shortly afterwards another member of staff walked in, picked the apron and tucked it into the person's clothing, saying, ''Here you are, to protect your clothes.''

People were not always well supported and respected. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Notwithstanding the above, most people told us the staff were good and respected them. Their comments included, "The carers are good but some of them, I have to take them as I find them… I am happy with the way I am looked after", "The staff are good people" and "Nobody's nasty. They are good to me."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● People's needs were not always met in line with their choices and preferences. Some people had complex needs and required one to one support and this was provided by agency care workers. Although agency workers received an induction to the service, we saw there were almost no interactions between them and the people they supported. They mostly sat watching people or followed them if they walked and did not support them with any activity.

● During our inspection, we noticed several people remained in bed all day with very little stimulation. One person's curtains were wide open and they had no music or television. Nothing changed for these people all day with the exception of staff attending to provide refreshment or personal care and when the door shut due to the fire alarm issue.

● People had keyworkers. A key worker is a member of staff who has responsibility for overseeing and coordinating the assessment and care planning process of specific people who use the service and to promote continuity of care. However, staff did not always seem to understand this role. One staff member told us, "I keywork three people. My main job is to make sure their rooms are tidy and their wardrobe is clean and sorted. It is ok I get on with them, some other residents are stubborn so it is harder to make sure their rooms are sorted properly."

● Some staff did not seem to understand how to support people in a person-centred way or give them choice. One staff member told us, "I think this is a good place for people to live because they know the schedule and when to expect things like tea time, everything is efficient."

The provider had not always ensured that the care and treatment provided to people was appropriate, met their assessed needs, or reflected their preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People's communication needs were assessed and recorded in their care plans. Assessments included the person's views, speech and language, vision and hearing and understanding and comprehension. Based on these, there were guidelines to staff to enable them to support the person in the best way possible to

support them. However these were not always followed by staff and people's communication needs were not always met.

● The registered manager told us where people had specific communication needs, they tried to meet these. They were trying to recruit staff who spoke the language of one of the people who used the service. We saw a member of staff using words in a person's language to communicate. We asked them if they spoke this language and they said, "I have learned a few words, so I can communicate with [them] a bit." However, most of the other staff did not seem to know how to communicate with this person and had not developed any systems of communication such as pictures or gestures.

● The registered manager told us staff used pictures to communicate with this person. However, we did not see any evidence of this on the day of our inspection. Mostly, staff gave instructions such as 'sit down', and an agency staff kept repeating a one syllable word which did not seem to mean anything to the person.

The provider had failed to ensure people's communication needs were met. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● One person was registered blind. Their record included a 'sensory/blindness' support plan. The person chose to spend most of their time in their bedroom. Guidelines to staff included, '[Person] prefers to have dimmer lights in their room to prevent glare, and also prefers the curtains to be drawn at all times'. Our observations confirmed this was respected by staff.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People were not always supported to undertake meaningful activities. For example, one person was fairly independent but mainly walked around all day. A staff member told us this person was more ''with it'' and was often bored because there was nothing to do. They had some interactions with staff but these were limited. No activities were offered to them and they were not given anything to hold or do during the morning.

● The provider employed an activities coordinator. They did not receive any specific training about how to provide meaningful activities to people who used the service. There was an activity plan developed by the company, however this did not reflect individual needs or interests. The activities coordinator told us it was flexible and they changed it depending on what people wanted to do.

● The activities coordinator told us they mostly spent time doing ball games, singalong or board games. We asked about people's individual needs and they said they chatted to people one to one and asked them about the photographs in their rooms. There did not seem to be any coordinated approach to planning activities around people's needs.

● There was no board in the communal lounges to let people know what was happening on the day. We mentioned this to the activities coordinator who acknowledged this would be 'nice for people to see'.

● On the day of our inspection, we did not see any evidence that people being supported in their bedrooms were provided with any activities or stimulation. Activity records we viewed confirmed some people were not supported to take part in meaningful activities.

The provider had failed to ensure some people received meaningful activities and were prevented from social isolation. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Activities were discussed during people's meetings, and their comments indicated they enjoyed what was on offer. For example, there were regular music performers visiting, a new bingo game had been introduced, and there were monthly movie screenings on a large screen. There were plans to turn one of the lounges into a permanent cinema room. There were regular outings and this had been popular with people. For

example, a trip to the war centre in Uxbridge.

Improving care quality in response to complaints or concerns

● Most people and relatives we spoke with said they were happy with the service and did not wish to make a complaint. One relative told us, "I find all the staff very approachable. If I have any concerns they listen and have acted on them. If I had major concerns I would approach the manager first, then CQC, but there is no need for that whatsoever."

● The provider kept a log of all complaints they received. We saw these were taken seriously and appropriate action was taken in a timely manner.

End of life care and support

● People's end of life wishes were recorded in their care plans. This included details about people's medical history and any religious or spiritual needs they may have.

● Where appropriate, 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms were kept in people's records. These were completed appropriately by the relevant healthcare professionals and included a summary of the discussion with the person or, where appropriate, their representative.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- We found there was a poor culture among the staff, where staff groups did not always work well together to achieve good outcomes for people who used the service. Staff openly spoke negatively about their colleagues to us. We discussed this with the registered manager and area director who acknowledged this was a problem and they were addressing this. On the day of our inspection, we saw staff arguing in full view and hearing of people who used the service.
- We found some staff did not show care or compassion for the people they supported. One staff member told us, "Night staff ignore me when I ask them to get people up to make it easier for us when we come in the morning. One night I did not put anyone to bed to show them because they don't help us…. I would normally put a few to bed to help the night staff out." They added, "I do not understand why they don't just shove some trousers on people when they change them, and they can go back to sleep afterwards, it would just make it easier for us."
- When asked what was good about the home, a staff member told us, "The best thing is break time, although I like speaking with the residents – some won't shut up but you learn life lessons."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider had a variety of monitoring systems in place. These included internal inspections, twice daily walk rounds and weekend spot checks. However, the application of these systems to monitor and improve the quality of the service had been ineffective and standards had deteriorated since the last inspection.
- The area director had carried out an internal inspection in December 2019 and found issues similar to the ones we identified during our inspection. However, no improvements had been made.
- Monitoring systems had failed to identify that, although risk assessments and support plans were in place, staff did not always follow these and we witnessed unsafe practices which put people at risk of avoidable harm.
- Medicines audits had failed to identify that staff did not always follow the provider's medicines policy in relation to medicines to be given 'as required', and medicines which were given covertly.
- Systems to monitor the service had failed to identify that the environment and activities available were not always suitable for people's needs in particular those who were living with dementia.
- Monitoring systems had failed to identify that people were not always treated with dignity and respect,

and their communication needs were not always met.
● Monitoring systems had failed to identify significant safety concerns which put people at risk of avoidable harm, such as staff not following health and safety and infection control procedures.

Continuous learning and improving care
● It was not always clear where learning took place. The service had been rated requires improvement for the last four inspections. This showed the provider's monitoring systems had continued to be ineffective. The provider had failed to learn from this and had not made the necessary improvements.

The provider did not have effective arrangements to assess, monitor and improve the quality of the service. This was a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the internal inspection, an action plan was put in place and the area director told us the home was being closely monitored. Following our feedback, the provider sent us a basic action plan telling us what actions they were taking to make the necessary improvements.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager understood the importance to be honest and open when mistakes were made, or incidents happened, and to offer an apology. They reported incidents to the relevant agencies and dealt with complaints in line with their policies and procedures.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and relatives were consulted via yearly quality surveys. The last one was conducted in June 2019, where the comments were mixed. Comments included, "Lovely care home", "Dinners could be more attractively presented" and "Overall the staff are all good, caring and professional." However, someone had commented that the lounge areas were bare and unstimulating and there was a malodour in the home. Following the survey, the provider had taken action such as spot checks of the environment to check cleanliness, speaking with kitchen staff to improve meal presentation and ordering wall art features to improve the environment.
● The provider kept a log of compliments they received from people, relatives or visitors. We viewed a range of these and saw comments such as, "[Family member] was made to feel most welcome and was included in social events and outings. Can't thank the staff enough", "Everybody was so kind. You all helped to make a difficult time easier to bear" and "Staff were caring and helpful from start to finish. The family will always be grateful."
● There were regular staff meetings taking place. Subjects discussed included safeguarding, internal inspections, health and safety and training.

Working in partnership with others
● The registered manager liaised with other social and healthcare professionals to learn from them and share information. They told us, "I join the Doctors, tissue viability nurse and pharmacists' visits, ask question and learn from them. I also learn from my staff because we all have different backgrounds and have worked in different fields of nursing."
● They attended 'My Home My Life training' through Hillingdon Social services, which is a qualification specifically for care home managers.
● They attended monthly managers' meetings organised by the company and attended regular provider

forums. They also liaised with other managers to share ideas and received guidance and advice from the area directors. Relevant information was cascaded to the staff team to support their learning and make them feel valued.

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 The registered person did not do everything reasonably practicable to make sure that people who used the service received person centred care and treatment that was appropriate, met their needs and reflected their personal preferences. Regulation 9 (1) (a) (b) (c) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person did not always ensure people were treated with dignity and respect Regulation 10 (1) (2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person did not always ensure that care and treatment of service users was provided with the consent of the relevant person. Regulation 11 (1)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The registered person did not always assess the risks to the health and safety of service users of receiving care or treatment. Regulation 12 (1) (2) (a) (b) (d) (e) (h)

The enforcement action we took:

warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The registered person did not have effective arrangements to assess, monitor and improve the quality of the service. Regulation 17(1) (2) (a) (b) (c)

The enforcement action we took:

warning notice