Cookridge Court Limited

Cookridge Court

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

Summary of findings

Overall summary

Cookridge Court is a 'care home'. People in care homes receive accommodation and personal care under a contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection. Cookridge Court is a residential home providing accommodation for persons who require personal care, some of whom are living with dementia. Cookridge Court has four units which included residential and dementia specialist accommodation. The units were called 'Court suite', 'Grange', 'Iverson' and 'Lawnswood.'

This inspection took place on 26 January, 1 and 5 February 2018 and at the time of our inspection there were 87 people living in the home. The provider registered with the CQC in August 2014 and has been rated as Requires Improvement or Inadequate for the past four inspections from January 2015 to October 2017.

The last inspection of this service took place on 17 and 30 October 2017and the service was rated as Requires Improvement at that time. Following the last inspection, we met with the provider to discuss our inspection findings and we also asked the provider to complete an action plan to show what they would do, and by when, to improve the overall rating of the service to at least 'Good'. At this inspection we found the provider had not taken appropriate steps to make the required improvements and they continued to be in breach of multiple regulations. We also identified new shortfalls in the service which exposed people to the risk of harm and abuse.

At the time of this inspection there was no registered manager 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.

We identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, namely Regulations 11(Need for Consent), 12 (Safe care and Treatment), 13 (Safeguarding service users from harm and abuse), 17 (Good governance) and 18 (Staffing). Full information about the CQC's regulatory response to the more serious concerns found during the inspection is added to reports after any representations and appeals have been concluded.

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.

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 provider had not always acted upon safeguarding matters and concerns related to risk, to protect people living in the home from harm. Incidents and accidents were not always reported which meant processes were not followed in accordance with the provider's policies and actions were not always taken to keep people safe from avoidable harm and alleged abuse.

Risk assessments did not always reflect people's needs. We found assessments had not been updated when there was documentation to suggest a risk was present or when serious incidents had occurred.

The provider failed to assess, monitor and improve the quality of the service and maintain accurate and robust care records. We found shortfalls in recordings; for example, Medication Administration Records (MARs), repositioning charts, care plans and audits were not always signed, updated or maintained correctly.

Audits had been completed. However, we could not be confident that these reflected all that had happened in the home due to the shortfalls in recording. Actions had not always been completed and there was a lack of information to determine trends and themes within separate parts of the home.

Most people living in the home told us they felt safe, although one person told us they felt unsafe due to an incident which had not been reported to protect the individual from harm.

We found the provider was not working within the principles of the Mental Capacity Act 2005. Care records did not include information to reflect that assessments had taken place where people lacked capacity, and the provider had not sought the views of relatives that were acting legally on people's behalf.

Initial assessments were not robust. There was no criteria to determine whether people would be best supported in the specialised dementia unit, or the residential unit of the home. We found people with progressed dementia living within the residential units due to a lack of beds in the dementia unit.

Care plans were in place but not always updated to reflect peoples' current needs and related risks. People and their relatives were invited to formal reviews of their care on a six monthly basis.

We could not be certain that staffing levels were safe as the provider failed to evidence that there were sufficient staff on duty at all times.

Staff were provided with regular supervisions, however, these were generalised and not specific to the staff member. Some annual appraisals had been completed to support staff development and any new employees completed an induction programme.

Appropriate checks were carried out to ensure staff working in the home were appropriately skilled and of

suitable character to do so. People and their relatives felt staff had sufficient training to do their job, however, staff told us they had not received training to support people with challenging behaviour.

Most people and their relatives told us the staff were caring and spoke positively about their relationships. However, we concluded that the provider was not caring as they failed to provide a safe and caring environment where the support people received was safe and of the minimum standard required to meet the requirements of relevant regulations.

People and their relatives spoke highly of the activities provided at the home. We saw regular activities, weekly timetables of planned events and monthly newsletters.

People told us the food served had improved recently. Fluid and food charts were used for people that required further support to maintain their nutritional needs, although, we found these records were not always completed properly.

People told us staff treated them with dignity and respect. We saw people being supported to be as independent as possible. End of life care was provided which was individualised to the person's needs and regularly reviewed.

Meetings took place in the home and annual surveys were used to gather people's views on the home. We saw regular meetings took place with people, to ask for their views.

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 management of people's medicines was not always robust.

We could not be sure that staff levels were adequate to meet people's needs.

Risk assessments were not robust and were not updated to reflect people's current needs.

The provider's safeguarding policy was not always followed. Some incidents had not been reported and showed a lack of action taken to mitigate risks.

Is the service effective?

Requires Improvement

The service was not always effective.

Where people lacked capacity to make decisions, care plans did not evidence compliance with the Mental Capacity Act (2005).

There was an induction and training programme in place for staff and although regular supervisions took place these lacked detail.

People were supported to have their nutritional needs met.

There were mixed views about the immediate support people received from health care professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us staff were caring. Positive relationships had been built between people using the service and staff.

Staff treated people with dignity and respect and supported them to be independent.

Staff involved people in their care planning.

The provider was not caring as they did not ensure a caring and safe environment in which people received their care, or a service that achieved compliance with relevant regulations.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Initial assessments of people's needs were carried out. However, these were not specific and there was no criteria to determine which unit could best meet people's needs.

Care plans were not always updated to reflect people's changed needs.

People were provided with a variety of activities which they enjoyed.

People were provided with choices and preferences regarding their care.

Is the service well-led?

Inadequate

The service was not well led.

We found shortfalls in the provider's governance and assurance systems designed to assess, monitor and improve the quality of the service and maintain accurate and robust care records.

Some confidential information had not been kept secure.

Audits were not robust and were not detailed enough to provide an overview of the service.

Surveys had been completed to gather people's views about the service.

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Detailed findings

Background to this inspection

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

This inspection took place on 26 January, 1 and 5 February 2018 and was unannounced. The inspection was prompted in part by a notification of an incident following which a person using the service was involved in a serious safeguarding incident. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with the CQC about the incident indicated potential concerns about the management of risk relating to safeguarding and this inspection examined those risks

This comprehensive inspection took place 26 January, 1 and 5 February 2018. It was unannounced on the first day and was carried out by one inspector and an assistant inspector. Day two included two adult social care inspectors, two experts by experiences and one specialist advisor. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Day three of the inspection was completed by one adult social care inspector.

Before our inspection, we reviewed all the information we held about the service, including previous inspection reports and statutory notifications sent to us by the provider. Statutory notifications contain information about changes, events or incidents that the provider is legally required to send us in order for us to monitor the service. We also contacted the local authority and other stakeholders to gather their views about the service.

During our inspection, we spoke with 15 people who used the service, 10 relatives, six care workers, the deputy manager, the area manager, the new managers, one administrator and the operations director.

We spent time looking at documents and records relating to people's care and the management of the service. We looked in detail at seven people's care plans, medicine records and a variety of policies and procedures developed and implemented by the provider.

Inadequate

Is the service safe?

Our findings

At our last inspection we found the service was not always safe and the provider was in breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014 as they had failed to monitor and mitigate risks appropriately and to handle medicines safely. At this inspection we found the provider was still in breach of this regulation and further shortfalls in respect of safeguarding vulnerable adults from harm and abuse were identified.

We found the provider had failed to ensure that people living in the home were protected from abuse or improper treatment because safeguarding incidents that occurred within the service were not always reported by staff or properly investigated. Staff did not always act promptly to protect people following incidents of a safeguarding nature. This in turn led to a disregard and neglect of people's care and treatment needs. We found eight safeguarding referrals had been completed in January 2018. Five of these allegations related to sexual allegations and the others related to physical abuse.

Most people living in the home told us they felt safe, however, one person told us they did not always feel safe and provided an example of when a man entered their room in the night and they felt threatened. The person told us they had pressed their call button for assistance from staff, however, the incident had not been reported to the management to prevent and protect the person from harm.

One incident report identified sexual interactions between two people living in the home. There was no immediate action taken by staff, according to the incident report, which stated the staff member left the room and went to get assistance. Upon return the bedroom door was closed and upon entering staff found further sexual contact between the two people. This showed staff did not immediately protect the person who lacked capacity from potential harm. We reviewed the provider's safeguarding policy which stated 'Immediate action to be taken. Ensure alleged victim(s) are comfortable and safe.' This did not happen because staff left the alleged victim with the alleged abuser. The alleged victim's care plan acknowledged their vulnerability.'

This is a breach of Regulation 13 (Safeguarding service users from harm and abuse) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not always assess the risks that both people and staff faced and therefore unnecessarily exposed them to the potential of suffering serious harm. We found five pressure sores, seven UTI's, one medication error, 11 physical incidents, five sexual incidents and 11 unexpected deaths had occurred within the service in January 2018.

One person had been involved in a physical altercation with another person in October 2017. We found a 'Challenging behaviour care plan' for this person from September 2017, however, this had not been updated to reflect the incident and the action taken to mitigate potential risk. The care plan stated 'Support [Name] through episodes of challenging behaviour in a way that causes least distress and helps [Name] to maintain dignity.' This did not provide clear instructions for how staff should manage the risk and how best to support

the person. We found that a second incident with the same person had occurred in December 2017 which resulted in multiple injuries. This showed staff did not have the information they needed to manage and prevent further incidents. We were also informed by staff that they had not been provided with challenging behaviour training.

One care plan stated a person should wear a support stocking on their left leg and that they required staff to put this on. We saw that this person had no support stocking on. The care plan stated the stocking was for the left leg, however, we were informed by the person it was their right leg. When asking the person, who had full capacity, if they wore the stocking, they told us it had not been put on for some time and it was, "A while since I've been seen by the district nurse." The person's right leg appeared very inflated, red and they said the swelling had increased which may have been due to not having the stocking on.

Accidents and incidents were not always being reported and therefore the provider did not have full insight of all incidents within the home to monitor risk. We found two incidents that had not been reported by staff. An incident when a person was found in another person's room and a medication error. For example, we found a person had not received their Alendronic Acid medication (for brittle bones) on 28 January 2018 and staff told us they had not informed anyone regarding the missed medication. We informed the deputy manager who reassured us action would be taken to ensure staff reported and recorded medication errors.

We found the management of medicines was not safe. We observed a medication round and found a prescribed medication for Parkinson's disease had not been administered at the correct time. This should have been administered at 12:00 however; this had not been given when we checked at 12.30. The impact of not receiving this medication could result in increased tremors and discomfort.

'As required' medicine protocols were not always written in accordance with dosage instructions. For example, one person used an 'as required' oral spray but there was no information on minimum time intervals for administration. One person requiring paracetamol did not have a protocol in place for administration, which meant staff did not have information on when this medication may be required. For discontinued medicines specified on the Medicines Administration Record (MAR), the reasons for discontinuation were not stated and it was not clear who had authorised the discontinuation. We found this to be the case for six medicines that were looked at.

The premises of the home was not always secure. Upon entering the building on the first day of our inspection there was no one in the reception area to check if anyone was entering the building undetected. On the same day we observed a male enter the building and walk into one of the units. Staff had not spoken to or seen the person enter the building. This meant unidentified persons could access the home without staff checking to ensure service users safety. Entrances to all units had a push button which automatically opened the doors. People entering the units could potentially allow or inadvertently support vulnerable service users to leave the home without staff knowledge.

The above concerns are a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We could not be certain that staffing levels were safe as the provider failed to evidence that there were sufficient staff on duty at all times. The regional manager told us there were a total of 13 people living in the home who required two staff to assist them with their needs. Five of these people resided on the Court unit, five on Iverson, two on Lawnswood and one in the Grange unit.

We reviewed the staff rotas on the second day of inspection as these were not available on the first day.

Staffing numbers did not correlate with the amount of staff required as stated by the regional manager. For example, on the 1 January 2018 there were seven staff working at night. On 29 January 2018 there were seven staff working at night and seven on the 4 February 2018. On the 4 February 2018 there were only two staff on the Court unit and two staff on the Grange and Lawnswood units. This meant that there was only one staff member on either the Grange or Lawnswood units during the night on this date.

The regional manager and operations director told us there were more staff on shift and we asked for evidence to confirm this. We have yet to receive this information and therefore could not be certain that staffing levels were adequate.

People using the service and staff told us more staff were needed. One person said, "One night I think there was only two (staff) …. Three weeks ago I used my buzzer. One carer comes in and says, 'I can't do you as you're a double' and said she would need someone to help her. She goes away and never comes back. This happened a few times." One staff member told us, "There are not enough staff…. If they are short of staff for any reason they take staff from another floor, well that only makes it difficult on that floor."

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

Emergency Plans were in place for individuals living the home and safety checks were carried out. At the last inspection we found infection control shortfalls and we found that these had been addressed at this inspection. We saw an audit had been completed and actions taken to address our previous concerns.

The provider safely recruited staff. The staff recruitment process included completion of an application form, a formal interview, the provision of previous employer references, proof of identity and a check under the Disclosure and Barring Scheme (DBS).This scheme enables the provider to check that candidates are suitable for employment with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we found the service was not always effective and the provider was in breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014 as they had failed to comply with the Mental Capacity Act (2005). This was because the process to evaluate the need for Deprivation of Liberty Safeguards (DoLS) was not always documented and mental capacity assessments were at times in accurate. At this inspection we found the provider was still in breach of this regulation and a further breach of Regulation 18 was identified, as supervisions and appraisals were not effective.

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

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

The provider failed to ensure that the Mental Capacity Act 2005 (MCA) and associated codes of conduct were appropriately applied within the service and care delivery. One mental capacity care plan stated a person had fluctuating capacity. We asked the operations director how this was determined, as there was no capacity assessment in the care file stating how this conclusion had been drawn. We were told by the operations director that individual capacity assessments were completed for every decision. The operations director confirmed there was no assessment in place to determine how they had concluded, in this case, that the person had fluctuating capacity.

We saw another capacity care plan which stated '[Name] has a diagnosis of vascular dementia and as such she lacks full capacity. What this means is she has the ability to make basic decisions about what to eat, drink, wear etc (however it is unlikely that she would have sufficient capacity for more complex decisions).' There had been no capacity assessment to show how this decision had been made. The care plan also documented the person lacked full capacity, however, this was contradictory as it stated the person was able to make some decisions at the back of the care plan. It stated a capacity assessment had been completed but we found no evidence of this within the care file. There was no date or signature to say when this capacity assessment had been completed.

One care file stated that a person's son and daughter held power of attorney (POA) for health and finance. We found no evidence within the care file that the son and daughter had been legally granted POA. The regional manager confirmed that the service did not have any evidence from the son and daughter that proved they held these legal positions as attorneys. The regional manager told us that this would be requested. The provider's mental capacity policy stated, 'The home should request a stamped photocopy of the Lasting Power of Attorney (LPA) as evidence of its existence. This should be held in the home accessible

to team members.' There was a risk that people's rights may not be upheld appropriately, due to the provider failing to ensure that relevant POAs were in place and family members making decisions on behalf of people, were legally entitled to do so in line with the MCA.

We concluded that the provider did not understand or act in accordance with the Mental Capacity Act 2005 which meant they failed to act lawfully to support people who lacked capacity to make their own decisions.

This is a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had an induction programme for new staff which mapped against the Care Certificate. This is a set of standards that social care and health workers follow as recommended by Skills for Care, a national provider of accreditation in training. The operations director told us they had recently introduced 'Positive behavioural support training', but most staff had not yet received this and were therefore expected to work with people who had challenging behaviour without knowledge about how to manage or mitigate associated risks.

The regional manager also used a training matrix to ensure staff kept up to date with their training. We saw courses which staff completed on an annual basis. These included, safeguarding, moving and handling, fire, infection control and food hygiene.

Supervisions and some appraisals had been completed, however, we found supervision records were not always detailed and were often generalised. For example, we found one record for a staff member which stated they were 'To ensure that after care re –positioned [Name], staff turn [Name]'s bed around so that she is not facing the wall.' The agreed summary stated 'To make sure that [Name] is not left facing the wall.' The supervision sheet also had another staff member's name on, which had been crossed out but the form was not re-written and the date for the next supervision session had not been recorded. Other supervision records were more generalised such as, 'MAR's must be signed when creams applied and all food charts must be thoroughly completed.' These meant supervision records were brief and did not reflect individual staff development and goals. This meant staff did not get effective supervisory support.

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

Staff we spoke to said they felt supported and one person said, "We have regular supervision - but you can see the team leader whenever you need to. I have lots of little informal chats with her on my own. We discuss training needs and the resident's needs."

People living in the home and their relatives told us, the food had improved recently following a quality control audit. Comments from people included, "Everything we eat is fresh", "Nothing is too much trouble for the cooks", "The food has been poor until recently" and "They have asked us for ideas to be included in the menus."

We observed lunch and saw people chatted together and appeared to enjoy the experience. There was a hostess who served meals and coordinated the lunchtime. Staff chatted with residents and were very attentive throughout. Meals were taken on trays to people who either wanted to eat in their rooms or who were unable to leave their bedrooms. During the day people were offered drinks and snacks were available. Fluid and food charts were in place for those people who needed their nutritional intake monitored. We found some recording issues where information about people's fluid intake had not always been recorded

correctly, however, we saw that people were gaining weight through monthly or weekly weight monitoring by the home.

People living in the home provided mixed comments about immediate access to health care. One person told us she had asked to see a doctor due to breathlessness. The person told us, "The doctor didn't come and nobody told me and then I was sick. I asked a second time to see the doctor. This was then at the weekend and they couldn't get a doctor and then the paramedics came. They were very good and checked me over and said I should go to hospital." Other comments included, "They make all the arrangements for me to see my specialists", "I see the district nurse regularly. They make sure of that" and a relative said, "They never hesitate to call the doctor if necessary - and they always keep me informed."

Requires Improvement

Is the service caring?

Our findings

At our last inspection we rated the service as 'Good' in this key question. Whilst we found that staff were caring in how they supported people with their needs on a day to day basis, we could not conclude that the provider or service was caring overall at this inspection. This was because the provider had failed to meet the minimum requirements of regulations, to minimise risks to people's health and wellbeing, and to provide a safe and caring environment in which people received care. Therefore we have rated this key question 'Requires improvement.'

People and relatives provided positive comments about the staff. Comments from people living in the home included, "The staff provide me with lovely care and respect", "The staff are so happy", "I love living here" and "Without exception the staff are kind to me." Relatives told us, "The staff know my mum so well. They can second guess her needs" and "The staff show [Name] such patience and understanding."

Our observations showed that staff treated everyone with dignity and respect. The interaction between staff and people demonstrated a genuine mutual respect, humour and an understanding of specific communication needs. One staff member said, "We have to maintain people's dignity. It is about making choices. All residents must have the right to choose what they want to do and when."

Staff respected people's privacy by knocking on doors and calling out before they entered people's bedroom or toilet areas. There appeared to be a good rapport between staff and residents. One lady was walking down the corridor and a care worker came up and asked if she was ok and chatted with her until she reached her room.

We saw people had boxes outside of their rooms which included memorable information about the person and helped people to find their bedrooms. People living in the home were encouraged to bring in personal items to decorate their room and make it personalised to them.

Meetings were held for people living in the home to gather their views about the service they received. The meetings included discussions on the food, activities, the home and any changes. People living in the home and their relatives told us they had recently been consulted about the quality of food, as previously this required improvement. One person said, "The staff are always asking if we want things to be improved." We also found people and their relatives were invited to participate when a review of their care needs took place. This showed that the provider involved people in their care.

We found some examples of when people's individual needs had been supported, for example, one care plan detailed a person's language needs. We saw pictures were placed in the care file which stated in both English and the preferred language what the picture meant. This allowed staff to communicate with the individual and meant the home had been mindful of people's diverse needs.

People were encouraged to remain independent, where possible. For example, one person living in the home had difficulty with their mobility and being able to move from their chair. We found the support from

staff had had a positive effect and the person no longer required positional changes as their independence had increased.

Information was available should people wish to seek advice and support from advocacy services. An advocate helps people who may require independent support to help them express their views.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we rated the service 'Requires improvement' in this key question. At this inspection the service remained 'Requires improvement' as the provider had not made sufficient changes to update care plans and ensure that initial assessments were robust so that people's needs were met.

We found initial assessments of people's care were not always effective. The home had two units for people living with dementia and two residential units. However, we found people with advanced dementia living in the residential units. We were informed that people living in the home with advanced dementia were waiting for beds on the dementia units, but that the provider could not currently facilitate it as there was a lack of beds available. There was no criteria set out by the provider for staff to determine what area people would live in and to what extent a person's level of dementia would impact upon which unit would best support their needs.

We found incidents had occurred on the Court suite which is for people who require residential care. Some people involved in the incidents had dementia and were often waiting to be moved to the dementia unit. Following such incidents people were often moved to the correct unit for their needs. This meant people were often living in the residential units but that their needs were higher than that of a residential care setting.

Care plans were not always updated. We found examples of when incidents had occurred and care plans had not been updated to reflect the person's changed needs and to mitigate future risk to others. One care plan related to a person's challenging behaviour where the person had been involved in three incidents in January 2018. However, the care plan was last updated in December 2017 which meant that it did not reflect the current level of support required. The lack of up to date information put others living in the home and staff at possible risk.

One mobility care plan stated that a person should be re positioned every two hours. There were no records that indicated the person was being repositioned as per their care plan. We were later informed by a staff member that the person no longer required re positioning as the person's mobility had improved and that this had been updated in their sleep care plan. However, the mobility care plan had not been updated which meant instructions for staff were contradictory.

There was a team of effective activity workers. The activity worker we spoke with demonstrated a commitment to the activities being enjoyable and beneficial. They displayed a full understanding of the physical and psychological benefits of activities on people's wellbeing. Without exception, people said that they took part in, and enjoyed, a wide range of activities and outings. People told us activities such as board games, jigsaws, various entertainers and parties took place. We saw an archery activity taking place during our inspection and an entertainer visited. People living in the home commented, "I love having my nails done. It is such a relaxing experience" and "I love the singers and entertainers. We can have a little dance. I love that."

One person's care plan outlined their choice and preferences for food and drink. For example, 'She enjoys tea and coffee with 4- 6 teaspoons of sugar. [Name] likes one meal a day as this is how she has always been in the past.' Other examples in the person's care plan stressed the importance of choice, for example, 'Staff to inform [Name] what activities are on and given the choice to participate or not.'

People living in the home and their relatives told us they knew how to complain. They commented, "I would be the first to complain if I was not happy with anything" and "I am not sure who the manager is, but I could tell the staff if I was unhappy." One relative told us, "The staff are so approachable. You can discuss anything with them."

Staff had a clear understanding of how to support people to complain should they wish to raise concerns. One staff member said, "So consider asking them to tell someone, or ask them if you can report it on their behalf. All the residents have a complaints procedure, but I think they lose them and forget about them. They are reminded at the residents meetings about complaints. I would have no hesitation to report a complaint. We all have the number for CQC too."

Complaints were managed by the provider. We looked at the provider's complaints file which included response letters, actions taken and apologies given when this was warranted.

We were informed that some people living in the home received end of life care. We observed that staff were knowledgeable about how to support people at the end of their lives in a dignified manner. They had mouth swabs available to them which they used to cleanse people's mouths should they become dry due to a lack of fluid intake. Syringes were also available to support people who could no longer drink out of a cup to have fluid via a syringe. One relative told us, "They try to give her sips of fluid and use mouth swabs but she has stopped eating now they are looking after her. I visit a few times a week and can keep an eye on her."

Inadequate

Is the service well-led?

Our findings

At our last inspection we found the service was not well led and the provider was in breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014 as they had not taken appropriate steps to ensure effective managerial structures were in place, resulting in a lack of stability or consistency in the service. The systems in place were not robust enough to ensure continuous improvement in the service. In addition records throughout the service were not always well maintained. At this inspection we found the provider was still in breach of this regulation.

The provider failed to assess, monitor and improve the quality of the service and maintain accurate and robust care records. During our inspection we reviewed the governance systems and processes in place that provided an oversight of the service. We found these were limited and not effective as they had failed to identify the numerous shortfalls and failings that we identified during our inspection visits.

Audits were not robust and some were hand written which made it difficult to determine any actions needed, or actions that had been taken, where improvements were needed. The regional manager said, following our inspection, that these audits were later typed up, but these had not been completed at the time of our inspection. Some of the audits had actions required to address identified shortfalls, but there was not always a date to say when these had been completed.

We looked at audits that had been completed in January 2018. The 'Dementia' audit stated, in a section for actions required, 'Section 8 reviewed on a monthly basis' this had been ticked to say completed however, we found section 8 care plan was dated 12 May 2016 and had not been updated following two physical incidents.

Each audit was completed on a three monthly basis and asked five questions to five people living in the home, as well as staff, about the quality of service delivered and how this had been achieved. However, some audits did not document the names of those people who were consulted on each occasion. The regional manager told us the audits were random with five people picked from different units within the home. This meant not everyone would be involved in the audit process because there was no record to see which people and staff had been previously consulted. In addition, there was no monitoring of individual units within the home. The home had both residential and specialist dementia units, but audits were completed for the entire home making it difficult to determine where there may be trends or themes that needed to be addressed in each individual area of the service.

Audits showed gaps in the consultation process. We found empty boxes for certain questions within the audits. For example, only two staff members were asked about their knowledge to identify three signs of abuse within the safeguarding audit. Five staff should have been asked. Only one staff member was asked questions in the end of life audit, rather than five staff being asked about this. A lack of information being gathered in audits meant there was no overarching view of the quality of service being provided.

The 'Safeguarding audit' asked questions to people which mainly focused on equality and diversity, privacy

and the MCA. This meant the audit was not effective in gathering people's views on safeguarding and ensuring people felt safe within the home.

Individual medication audits were not effective as there was no structure in how these were organised and how often they were completed. The regional manager said the audits for medicines were undertaken randomly by the team leaders/managers. However, the deputy manager was unable to provide individual medication audits for any of the 11 MARs we checked. This meant not all MAR's had been audited to ensure errors were not being made.

Medication audits had not identified the issues we found during the inspection. Where issues were identified there were inconsistencies in the completion of action plans. For example, we found an audit completed on 16 January highlighted that controlled drugs checks had not been completed and at the next audit, completed 30 January, the same issue was raised. We found no action plans had been documented to show who would be responsible for driving improvements in this area and when actions needed to be completed by.

We found records were not robust. MAR records were not always accurate, for example, dosages of medicines administered were not clear and times not documented for the administration of 'as required' medicines. Medicine fridge temperature records were not always accurately recorded to ensure that medicines were stored appropriately and they remained safe for use. Care plans relating to risk had not been updated with some being over 12 months without having been reviewed. For example, one care plan entitled 'Capacity' had not been updated since May 2016. Another care plan had been written in two different types of hand writing making it difficult to determine whether information added was old or new information, as it had not been signed or dated.

Visual observations on people by staff were not always recorded accurately. For example, on 19 January 2018 according to their care records one person should have been observed every 30 minutes, but there was no record of any observation of the person at 6pm, as required. One observation chart was unclear, with times crossed out and re-written, making it difficult to determine what time the checks were carried out. Another visual observation chart had both the 30 minute and 15 minute observations ticked making it difficult to determine how often the person should have been observed. We found some entries completed every 15 minutes and others completed every 30 minutes. We also found a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) which had not been updated after the person had moved into Cookridge Court. The address written on the DNACPR was the person's previous home address, however, this had been crossed out in pen and 'Cookridge Court' had been written on this.

There was a lack of recording on MARs we reviewed. For example, one MAR had four missed medicine administrations in a 24 hour period and one missed medicine administration on another day. We found recordings for a patch application site had not been documented for 15 days. This is necessary because the application site needs to be rotated to prevent skin damage.

Confidential information was not always kept secure. We observed two staff sat in a communal area (dining room) with care notes open and writing daily entries. At the table, a person living in the home was sat in front of them and could clearly see this information, which should be kept confidential. During a walk around of the home on our last day of inspection we found care notes had been left out on the staff desk. This included information about people's hospital appointments which should have been kept secure to avoid others being able to see private information about people's care.

The service does not currently have a registered manager. The regional manager had been acting as the

home manager until the permanent post could be filled. At the inspection two new managers had been in post for less than one week. The provider had employed both a home manager and general manager to improve different aspects of the home. At the time of our inspection the provider was in the process of making a decision as to which manager will become the registered manager.

The service delivered at Cookridge Court has been rated 'Requires Improvement' or 'Inadequate' for the past five inspections, which shows a lack of improvement over a sustained amount of time.

The above concerns are a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Surveys had not been sent out since the last inspection in October 2017. The provider gathered feedback from people living in the home and their relatives using an annual survey. The last survey showed there had been some improvements, however, most answers provided were below the average target set by the provider.

The provider introduced 'pace setting training' which focused on the provider's visions and values, namely, 'make every moment matter, keep it simple, do it from the heart, choose to be happy, sort it.' The administrator told us staff were encouraged to adopt these values and had organised events to incorporate team work. For example, they had completed a day with team building exercises and changed the staff room to improve morale, and displayed the values so staff had this as a positive daily reminder.

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 11 HSCA RA Regulations 2014 Need for consent The provider did not always comply with the Mental Capacity Act (2005) as the process to evaluate the need for Deprivation of Liberty Safeguards (DoLS) was not always documented and mental capacity assessments were at times in accurate.

The enforcement action we took:

We took enforcement action but this did not proceed as the provider made some improvements at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a failure to implement risk assessments when serious risks had been raised, the provider did not do all that was reasonably practical to mitigate any such risks. There were also failings to ensure the safe management of as required medicines and the premises of the home was not always secure.

The enforcement action we took:

We took enforcement action but this did not proceed as the provider made some improvements at the service..

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not always follow the systems and processes in place which ensured people were protected from avoidable harm and abuse.

The enforcement action we took:

We took enforcement action but this did not proceed as the provider made some improvements at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to follow systems in place to assess, monitor and improve the quality and safety of the service provided. There was failure to maintain accurate and complete records.

The enforcement action we took:

We took enforcement action but this did not proceed as the provider made some improvements at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staffing levels were sufficient to meet people's needs.

The enforcement action we took:

We took enforcement action but this did not proceed as the provider made some improvements at the service.