Healthcare Homes (LSC) Limited

Cedar Court Care Home

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

This inspection took place on 25 October and 1 November 2017. Both visits were unannounced.

Cedar Court is a care home registered to provide accommodation for people who require personal or nursing care. It is located in a purpose-built facility and can accommodate up to 63 people whose care needs are associated with physical needs, mental frailty and/or dementia. At the time of our visit 43 people were using the service, most of whom lived with dementia. Prior to our inspection, we had received concerns about staffing levels, people's safety and lack of social interaction between staff and people.

There was a registered manager in post at the time of our inspection. However, the registered manager resigned from their post after the first day of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There was a high number of people at the service who needed two staff members to assist them with their personal care and when mobilizing using a hoist. However, the staffing levels were insufficient to meet the needs of people. As a result, staff were occupied with providing care in people's bedrooms without being able to spend enough time engaging with people. This meant that when staff provided care to some individuals, other people were left without the care and support they needed for significant periods of time. This was evident from our observations and discussions with staff and relatives. Some relatives were concerned that they could not locate staff when they visited the home.

We could not be sure that people received assistance from staff when they needed it, because call bells were not available to some people. There was no alternative system in place for people to call for assistance.

Risk assessments and care plans were in place for each person. Although risks to people had been identified, the steps to be taken to deal with those risks were not always clear. Care plans did not always give enough detail to staff to enable them to manage those risks. People did not receive appropriate monitoring which placed them at increased risk of harm. For example, people were not always supported to eat and drink.

The premises were not free from offensive odours. The odour of urine was noted in different places, such as people's rooms and the communal areas, in the course of the inspection. The home was unclean, both people's bedrooms and the communal areas were untidy.

Although staff had received training in relation to the Mental Capacity Act (MCA). However, this learning was not applied. Capacity assessments were not decision-specific or individualised for each person. Where people lacked capacity to make decisions, capacity assessments and best interest's decisions were not completed where they should have been, for example in relation to the use of bed rails.

We observed interactions between staff and people. We found the culture of the service to be task focused. Meeting the individual needs of people was not priority in this culture. End of life care plans were in place, however, due to the low staffing levels staff could not spend time with people in the last days of their lives.

People's social needs were met on a group level, however, due to the staffing levels the service was unable to meet individual social needs of people.

The provider had a range of quality monitoring arrangements in place to monitor care and plan ongoing improvements. This included audits, surveys and regular health and safety checks. However, the systems in place had not identified the shortfalls found at our inspection.

People were protected by the provider's recruitment procedures. The provider made appropriate pre-employment checks to ensure that only suitable staff were employed. Staff understood their responsibilities in terms of safeguarding and knew how to report concerns if they suspected abuse.
Medicines were administered as prescribed.

Staff were provided with an induction when they started work, which included mandatory training and shadowing experienced colleagues. Staff told us they received one-to-one supervision and this was demonstrated by the records we checked.

The home had a robust complaints policy and records showed complaints were responded to in line with it. People and their relatives told us they knew how to make complaints.

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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staffing levels were insufficient and therefore staff could not be effectively deployed and available at all times to meet people's care and treatment needs.

People could not be assured they would receive assistance from staff when they needed it because in the absence of call bells there was no alternative system in place for people to call for assistance.

Risk assessments were inconsistently completed and were not clear about what measures staff should take to mitigate risks to people.

Suitable steps were not always taken to minimise risks to people.

People were not consistently cared for in a safe and clean environment.

Staff understood safeguarding procedures and knew how to report any concerns regarding abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Consent to care and treatment was not always sought in line with legislation and guidance.

Most people enjoyed the food provided at the home and were satisfied with the choice of meals. However, records did not always reflect whether people's nutritional needs were met.

Staff had completed training to enable them to provide people with care effectively.

People were supported to have access to health professionals to help them have their health needs met.

Is the service caring?

Requires Improvement

The service was not always caring.

Whilst some staff members treated people in a kind and compassionate manner, this attitude was not always demonstrated by others.

Most of staff were doing their best to be caring. However, the context in which they were working compromised this.

The lack of opportunities for engagement with staff affected people's experience of care at the home.

People could not be assured their confidentiality of information would be protected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not always reflect people's current care needs and lacked sufficient information and guidance to instruct staff how to mitigate risks to people's health, welfare and safety.

People did not always receive the care and treatment they required at the times that they needed or wanted it.

There were few opportunities for people to participate in activities, and people told us there was little to occupy their time.

Complaints were managed and investigated appropriately.

Is the service well-led?

Inadequate

The service was not well-led.

The quality and safety monitoring of the service was ineffective and failed to identify where the quality and the safety of the service were being compromised.

People were not always protected from unsafe care because accurate and up-to-date records were not maintained.

The views of staff about the management support they received were mixed.

Cedar Court Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 25 October and 1 November 217 and was unannounced. The inspection on 25 October was carried out by two adult social care inspectors, a specialist advisor who specialised in nursing care, and two experts-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our experts-by-experience had through knowledge of supporting people who were living with dementia. On 1 November 2017, two adult social care inspectors returned to the service.

Concerns about staffing levels, people's safety and lack of social interaction between staff and people had been raised with us prior to the inspection. Having taken these concerns into consideration, we decided to bring our planned inspection forward. We reviewed information we held about the service. This included any information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We also contacted commissioners (who fund the care for some people) of the service and asked them for their views.

Some people could not convey what they thought about the home because they were unable to communicate verbally. Therefore we used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care in order to understand the experience of people who could not talk to us. We observed how people were supported at lunch and watched how staff interacted with them at that time. After the second day of the inspection, we contacted further five relatives to obtain their opinion on the service provided by Cedar Court Care Home.

During the inspection we spoke with 12 people who were using the service. We also talked to three family members. We spoke with the registered manager, the deputy manager, the regional director, the registered nurse and three members of staff. We looked at the care records for five people, including their assessments,

care plans and risk assessments. We looked at how medicines were managed and examined the records relating to this. We looked at five staff recruitment files and other records relating to staff support and training. We also looked at records used to monitor the quality of the service, such as the provider's audits of different aspects of the service.

Inadequate

Is the service safe?

Our findings

It had been brought to our attention before the inspection that there were not enough staff to support people safely at Cedar Court. At this inspection we found the number of staff to be insufficient to support the high number of people who needed the assistance of two staff members at a time. This was evident from our observations and discussions with staff and relatives.

We spent time observing people's experience in the communal areas such as the corridor, lounge and dining room. Staff did not have time to spend speaking with people. As a result, people were left without any form of interaction for significant periods of time. Staff were observed to be rushed and task focused and did not work at a pace that suited the needs of people isolated in their rooms. A large number of people staying in their rooms, nursed or confined to bed, did not have access to call bells. They were totally reliant on calling out, often in a distressed manner, or relying on carers' visits which had no regular pattern. Staff had little time for social interaction with the residents and were passing the rooms without speaking to people unless a resident shouted out. One person told us, "All the residents see is the back of the carers".

Relatives told us staff worked hard to meet people's care needs but did not have time to engage with people. One person's relative told us, "I don't think they have enough staff to go round. I hear others [residents] calling out. Staff seem to be used to it and take no notice". Another person's relative pointed out that the insufficient staffing levels resulted in the poor quality of care. The relative told us, "I come in sometimes and she has breakfast all around her face. I don't know the last time she had her hair washed". Another person's relative told us, "[Person] is always waiting for personal care when I come in".

People and relatives told us that staff were rushed to complete their tasks which affected the quality of care received by people. One person's relative told us, "I came in yesterday and found [person] lying in bed like a sack of potatoes. No reason for it. Her nightdress was undone. She has a thing to stop her legs banging together, found that being used as a pillow instead. She has been here for three years, they should know what happens". Another person's relative told us, "It does sometimes take a while to find someone (staff)".

We saw and people told us that staff were too busy to monitor people which led to people walking into other people's bedrooms and using other people's items. For example, we saw one person was walking with another person's zimmer frame, finally leaving it overturned in the middle of the corridor, creating the risk of tripping to other people. One person who chose to stay in their room told us, "A wandering man comes into my room most nights. I'm in bed awake and watch him go to my wardrobe and look in, then he goes out". We asked the person if they could press the call bell to call for staff help. The person told us, "No, because he would be gone by the time they got here". One person's relative told us, "Upstairs (the dementia wing) is dangerous. I saw three incidents where people were attacked and pushed in the lounge. It is an absolute chaos at times. I've been seized from behind, been slapped and someone tried to gouge my eyes. No one is supervising this and relatives are not told about the incidents. You can call and nobody comes". Another person's relative told us, "So many things were broken in the room by other people. I bought two bubble lamps and both got broken. I have given up bringing things in. There is lack of supervision".

The staff we spoke with were clear that they did not have time to spend interacting with the people they cared for and getting to know them. They understood that people needed social interaction for their continued well-being and were frustrated the lack of time prevented them from fulfilling this aspect of their role. A member of staff told us, "We have been short. It has impacted on us and staff are stressed. They try their best. Really and truly it's just the staffing levels. So sort that out and everything will fall into place".

Staffing numbers were inadequate for the number of people who required two staff members to support them with their personal care and hoists transfers. We asked the staff on shift about people's current care needs and staffing levels on the second day of the inspection. Staff confirmed that there were 22 people in the nursing wing, 12 of them required assistance of two members of staff. There were 21people living in the dementia wing and 15 of them required the assistance of two members of staff. We observed that the service failed to meet the needs of people because insufficient numbers of staff were effectively deployed to match the needs of people who required double-handed care.

The registered manager told us that staffing levels were calculated using a dependency tool, which assessed people's needs on a regular basis to ensure staffing levels were appropriate to meet their needs. However, we found that the risk assessments that aggregated the dependency tool were not always accurate and did not always reflect the needs of people. For example, one person required support with personal care and repositioning. The person had no moving and handling risk assessment in place that would suggest appropriate staffing levels. Another person using a zimmer frame and at risk of falls had their mobility score estimated as zero. According to the system used by the provider, they should have at the very least scored three. This score did not reflect the needs of the person but was used to calculate the dependency tool for them anyway. This meant the tool was not used effectively to predict staffing levels. A member of staff told us, "They keep telling us we are staffed adequately but we're not".
There were contingency plans regarding staffing levels. For example, there was a plan on how to cover unexpected staff members' sickness by replacing them with other staff. However, the agency staff in charge of the nursing wing did not follow the contingency plan. This resulted in shortage of staff during the second day of our inspection.

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

There was a system of recording that included risk assessments and care plans. These were completed by registered nurses and reviewed monthly. However, records relating to people's care needs were difficult to follow. Neither key areas of risk nor instructions or guidance for staff on how to manage the risk was presented in a logical pathway. For example, areas of risk such as malnutrition or pressure care were identified individually within risk assessments, but did not lead to a clearly defined plan of care in these areas. One person's care plan stated they were supposed to be regularly repositioned, however, the care plan did not specify the frequency of repositioning. Another care plan stated the person was supposed to be checked on every 20 minutes by a named member of staff. This was impossible to accommodate due to the low staffing levels and due to the fact that the named staff could not work every single shift. The care plans did not specify guidance and objectives sufficiently. We saw that most of the care plans were instructing staff to visually check on people, however, staff were not advised about the frequency of the visual checks. Entries made in the daily logs by staff showed that people were monitored by staff roughly at three hour intervals in the daytime. However, the gaps at night were four hours long. This meant appropriate measures were not in place to minimise people's individual risks.

One person had a food and fluid chart in place due to weight loss, which had been introduced on the day prior to our inspection. Entries had been made for the day prior to the inspection, but staff had not totalled

up the person's intake and there was no guidance for staff on how much fluid this person should consume. Staff did not make any entry and did not monitor the person's intake on the first day of the inspection. On the second day of the inspection we saw that staff continued to complete the chart. However, the person's intake was not consistently totalled up and there was no set goal regarding the person's hydration, rendering the food and fluid chart useless.

We observed some people had no access to call bells. There was no alternative system in place for these people to alert staff if they needed support. This meant that people were unable to call for assistance if needed and had to wait for staff to check on them. One of the relatives told us, "There are not nearly enough of them (staff) now and he is totally blind. No call bell, so he can't get help". Another person's relative complained, "Somebody should be going round more frequently than they do. They (people) don't have a bell, don't see anybody. How do they get help"?

The environment in which people were provided with care was neither safe nor clean. In a number of people's rooms we could smell a strong odour caused by unclean carpets. However, in some other cases the unpleasant smell was caused by issues relating to people's personal care. A health care professional told us, "I feel that the environment needs to be upgraded. The odour can be overpowering". The shared bathroom and toilet facilities were clean and tidy during the day time of the first day of inspection. However, we noted early in the morning on the second day of the inspection that the communal bathrooms in the dementia wing were very dirty as the night staff were busy carrying out other care-related tasks and had no time to clean the bathroom.

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

Most of people and their relatives told us they felt people were safe living in Cedar Court Care Home. One person told us, "It is not too bad. I feel safe as people from the outside can't get into premises". Another person said, "I feel very safe here". One of the relatives told us, "[Person] is safe enough because she doesn't get out of bed".

Staff were aware of their responsibilities for protecting people against the risk of avoidable harm and abuse. They were able to give us hypothetical examples of a risk of someone being abused and the steps they would take to protect that person. Staff told us they were able to recognise signs of abuse. A member of staff explained what these signs may be, "Sometimes a resident may be upset, withdrawn or have bruises and finger marks on their body". Staff described how they would refer people to appropriate organisations to ensure they were protected from potential abuse. This included the local authority safeguarding team and the Care Quality Commission [CQC].

The service responded appropriately to safeguarding concerns. We found that all safeguarding notifications had been submitted in a timely manner and internal investigations had been carried out where required. For example, one internal investigation had revealed that some people had got bruised when a large number of agency staff had worked at night. The registered manager had addressed the issue by raising this with the agency. The manager had immediately arranged that the agency staff had been provided with brief refresher training on moving and handling by one of the senior members of staff.

Recruitment procedures were thorough to make sure that staff were suitable to work with vulnerable people. Checks were completed to make sure staff were honest, trustworthy and reliable. This included completing an application form, evidence of a Disclosure and Barring Service (DBS) check having been undertaken, proof of the person's identity and references from previous employments. The DBS helps

employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Medicines were stored safely and securely. Temperature records for the medicines refrigerator showed that medicines requiring refrigeration were kept within their recommended temperature ranges. Medicines were administered safely. All the people we spoke with told us they received their medicines regularly and they were observed whilst taking them. We found that medicines were given on time and the medicine administration records (MAR) charts were completed to show what medicines people had received, as well as when and in what amounts they received them.

Each person had a personal emergency evacuation plan (PEEP). A PEEP sets out the specific physical and communication requirements that each person had to ensure that people could be safely moved away from danger in the event of an emergency.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA. People's call bells risk assessments stated that the call bells had been removed as people had no capacity to use them. However, there were no records of mental capacity assessments or best interest meetings recorded for the removal of the call bells. The service had not ensured that where service users had their call bells removed, this had been done following the correct and safe legal processes.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The service did not follow the principles of using the least restrictive option. For example, one person's bed rails risk assessment indicated they did not need to use bedrails. However, we saw the person had bedrails in place. The required consent form had been signed by a member of staff on behalf of the person in question. However, there was no record of a mental capacity assessment having been completed nor a best interest process having been followed. We also found that one person had a DoLS application in place without their mental capacity having been assessed in advance. The registered manager was unaware of the breach.

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

On the first day of the inspection we noted that people who had no access to call bells were left without any food or fluid at hand. The first person we visited in the dementia wing asked us for some water as they were thirsty and unable to call for help as they had no access to the call bell. We noticed that the person's beaker cup full of tea and the remains of food lay on the floor below their bed. The beaker cup was cold which suggested this had been brought to the person's room long enough to cool down completely. We raised this issue with the registered manager immediately and we checked the other people in their bedrooms. We found six more people did not have access to call bells and had no food or water in their rooms. One of the carers provided people with tea, however, people were not assisted to drink it. We observed that staff did not ensure people had a drink within reach. Even when people were provided with fluids, they were not regularly encouraged to drink. In some cases the fluid level in beaker cups remained unchanged for several hours. Tea, biscuits and snacks were brought to people. However, many biscuits and beakers of tea remained untouched, largely because people needed support with drinking or eating which was not available to them due to the low staffing levels. A member of staff told us, "We feel we struggle to meet their needs, the impact of assisting feeding is huge. More staff would help and we would get more done".

One person told us that they would like to drink their tea but could not do it as there was something wrong with their cup. We checked the person's care files and found the person was supposed to have a straw with

their cup of tea and this had not been provided to them. The person could not drink their tea until a member of our inspection team provided them with a straw. Another person asked us for a drink which we gave them. The person drank down a full beaker cup straightaway once we showed them how to use the specialist drinking beaker. Another person's food chart stated finger food was best for them. The person was attempting to eat finger food, however this was cold (even though it was supposed to be served hot) and it was two hours after lunch time when we visited them.

People eating in the dining room were supported by staff and had their meals served at around 12.35pm. People staying in their rooms were provided with meals up to an hour later. We saw that staff had forgotten to bring food to one person and this person had to wait for their food until around 2pm.

People's relatives told us they were afraid people's nutritional needs were not met due to the insufficient staffing levels. One person's relative told us, "[Person] sleeps a lot and if he is asleep when the meal comes, they should feed him later. I know they don't do it, they are too busy".

We also observed the nursing wing and identified similar issues. For example, we observed two people who were nursed in bed and whose bowls of soup remained untouched and cold on their bedside tables. We asked one person why they had not eaten their meal. The person told us, "What's the point, I can't reach it anyway".

People did not always get their choice of food and staff were not always knowledgeable about people's food preferences. On the first day of the inspection the agency chef had to provide people with food that was not on the menu as they could not manage to provide them with the options previously offered to people. On the nursing wing dining room, one person noticed that there was a jug of lemon juice on the table during lunchtime. They told us, "It's funny because neither of us drink juice". We asked another person if they were offered biscuits with their tea. The person said, "You never see biscuits. You have to ask for those". One person's relative told us, "Mum has pureed food and thickened juice. I go in at lunchtime most days. The only problem is that a carer stirred today all the food together so instead of a white blob, green blob and a brown blob it ended up as a brown mush".

On the second day of the inspection we found that most of the people living on the nursing wing had access to fluids, however, sometimes these were out of their reach. On the dementia wing most of the people who had their call bells removed were left without access to any fluids.

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

We received mixed opinions from people and their relatives regarding staff's skills and knowledge. One person told us, "I think they do very well know what they are doing. But they are all very busy. Too busy". Another person seemed satisfied with their carers, "The staff are good, I like the young ones". One person's relative told us, "Staff lack understanding and they need training in how to deal with his condition. If they improve the understanding of the illness, this would be a great help". Another person's relative told us, "They should not use agency staff. I consider them untrained, occasionally one or two are pretty good".

All new staff were obliged to undertake induction training which included the completion of mandatory training in relevant areas and completion of a probationary period. Newly employed staff shadowed more experienced staff for two weeks and had their competencies assessed.

Staff received on-going training in areas such as dementia care, safeguarding or moving and handling

equipment, in order to meet people's specific needs. In addition to in-house training, specialists from external professionals, including the; Care Home Support Service (CHSS), a local hospice, Hospital at Home, and a brain injury support group, came in to offer specialist training around positioning, end of life care and acquired brain injuries. However, staff told us they would like to receive more classroom based training as they were struggling to spare enough time to complete e-learning training. A member of staff told us, "Training is not our strong point. Even though we now have a training officer, which should help. There's quite a lot of online training which we have to do in our own time as we have no time to do it in our work hours".

Records showed and staff confirmed that staff received regular supervision sessions. The supervision records showed the meetings had been focused on discussing such areas as 'dignity and person centred approaches'. Where issues of poor practice had been identified, this had also been discussed with the staff member. However, supervision meetings tended to be focused on care tasks and did not provide a lot of opportunities to discuss staff's own issues and feelings.

People were supported to maintain good health by accessing health care services and obtaining advice from a range of professionals. These included GPs, chiropodist, psychiatric nurse, dentist and an optician, and other professionals from the Care Home Support Team (CHSS).

Requires Improvement

Is the service caring?

Our findings

Confidentiality was not always maintained. For example, in the early morning of the second day of the inspection we found that the door to the dementia office containing confidential information was left wide open. There were no staff in the office and some people were already walking down the corridor. This led to the confidentiality of data being compromised as any person could walk into the office and access personal information such as care plans with people's personal information.

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

We asked people and their relatives if staff treated them with dignity and respect. Some people told us that staff were very nice and kind to them. For example, one person told us, "The carers are like members of the family". Another person said, "I'm alright here. When they do have the time, they do chat with me". However, other people and relatives told us staff did not always treat people with respect and dignity and the service was not always caring. One person complained to us, "Some of the carers are perfect, some don't talk to you and that cheeses me off". Another person said, "'This place is very nice, except the carers are not very good. They won't take any notice of me". One person's relative told us, "Staff are ok but what is worrying me is that they talk about her to me in front of her. When I am there, she (staff member) tells me this and that and she (person) knows what is going on". Another person's relative said, "When I go in, I don't feel I know what's going on. Surely they feel that 'she is a nuisance' when I ask a question".

During our observation on the first day of the inspection we noted that staff did not always treat people with due respect and dignity. For example, staff working in the dementia wing did not always knock on the door before entering people's bedrooms. On one occasion we heard a member of staff telling one person to stop shouting in an abrupt tone of voice. During lunchtime we saw that staff were talking mostly about feeding people instead of assisting people with their meals. We saw that the low staffing levels made it impossible for staff to have a chat with people and to engage them in a meaningful conversation. This was confirmed by people and their relatives. One person told us, "The carers rush because they've got a lot to do and no one stops for a chat". Another person said, "Kind people (staff), they do care. They are quite busy and they have time only for an occasional chat".

People's records included their decisions about their end of life care. The advanced care plans recorded people's wishes and choices as to how they would like to be treated in their last days. Staff were knowledgeable about the end of life care, however, they were frustrated as the low staffing levels did not allow them to spend time with people in the last moments of their lives. A member of staff told us, "We try to find time to sit and hold someone's hand. However, we are aware that other people need our help. It's a real conflict and it's quite sad".

People's relatives told us they were regularly contacted by the service. One person's relative told us, "Staff do phone me. [Person] recently got an infection and they phoned me to let me know". Another person's relative asked about the frequency of their contacts with staff said, "Every day, so if something has

happened that's minor they tell me then. I am sure that if it was serious then they also would let me know". However, people's relatives and staff told us that some information was not always passed to them so sometimes staff were not able to provide people's relatives with the information they requested. One person's relative told us, "Communication is the biggest downside here. If I come in and [person] was seen by GP, and I ask staff for some information they may tell me but they do not know about it because they have not been on duty". A member of staff told us, "The flow of information could be quicker".

The staff we spoke with were very dedicated to their roles. We spoke with a member of staff who had come into the service to help voluntarily on their day off. The member of staff told us, "It is difficult sometimes but I absolutely believe in the team here, the spirit is good and I've made friends here". Another staff member told us that several off duty staff came in to help voluntarily when the service was flooded last summer.

The service had an equal opportunities policy in place. This confirmed the provider's commitment to equal opportunities and diversity. The policy included cultural and religious backgrounds as well as people's gender and sexual orientation.

Where appropriate, people were provided with information on the service in an easy to read format. During the inspection the service was in the course of preparing an action plan after a recent survey and one of the points of the action plan was to publish the results in an easy to read format.

Requires Improvement

Is the service responsive?

Our findings

The provider employed one full time and one part-time activities co-ordinator in the service. People who were able to participate in group activities told us they were happy with their activities. One person said, "There are things to do. I like the singing". Another person told us, "There are plenty of things you can take part in. I like the quizzes and the musical things". One of the care co-ordinators told us how the organised activities helped people feel more secure and improved their concentration. The activities co-ordinator said, "When [person] came here, he was very introverted, very insecure. He needed reassurance 24/7. Gradually, we involved him in a one to one activity. Now he likes to be in a group, happier with himself and so pleased with what he achieved".

However, people who stayed in their rooms told us they lacked any social interaction. One to one activities were impossible to be provided to so many people cared for in bed with the staffing levels. A member of staff told us, "They (residents) need to be kept busy but they are not doing things. You can't do that with three staff when 13 people need one to one support. There are times we could get people out (to group activities) but it is impossible time-wise. It has become the way it is". People who stayed in their rooms and their relatives told us there were not enough activities and outings organised for people. One person said, "There is nothing to do here. Anything would improve your life. For example, I'd like to get out more". Another person remarked, "I feel lonely, very lonely". Two other residents told us, "I would like to go out but staff too busy" and "I would like to get out more but there is nobody about to take me". One person's relative pointed out, "I get the impression that once the Dementia reaches a level, then they (residents) are just things in a bed". Another relative told us, "There is nothing to do but he loves to talk. People came in to assess him and put up a notice saying 'please try and spend time talking to [person]'. A few days later the notice had been taken down. Due to the shortage of staff and no time I suppose".

People and their relatives told us that the service was not always responsive to people's needs as staff did not always have time to assist people. One person's relative told us, "I suggested that I would like her to get out of the bed. A carer told us to get her [person] a special wheelchair which we did but she has only used it a very few times. Because she hasn't been out of bed, her limbs have become rigid and now they have difficulty hoisting her. I know she would love to go and listen to the singing. I don't really think they have the time to assist her". Another person's relative told us, "They need more staff to individually look after him and take him out for half an hour or so. I would love him to meet other people on his wavelength".

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

Each person had their needs assessed before they moved into the home. The aim was to make sure the home was appropriate to meet the person's needs and expectations. Following the initial assessments, care plans were prepared to ensure staff had sufficient information about how people wanted their care needs to be met. However, one of the professionals told us that the initial assessment did not always reflect the actual needs of people which resulted in high a number of referrals. The health care professional said, "The initial assessment can be a downfall at Cedar Court. Very often we receive referrals just two weeks after

admission. It's about asking more questions before accepting somebody".

The care plans and risk assessments were regularly reviewed. Most of the relatives told us they were involved in people's care and they took part in the reviews of people's care plans. One person's relative said, "I speak to the nurses once a year. I'm always involved in [person's] care". Another person's relative told us, "Yes, I'm involved because I ask to look at the care plan". However, some people's relatives told us they did not always feel involved in people's care. One person's relative said, "At the beginning we had formal reviews. We have them no more, just a brief chat now and again".

The service had a complaints policy and procedure. The registered manager and staff were able to explain how they would deal with a complaint. In the last year the service had received ten complaints which had been dealt with to the complainants' satisfaction. One person's relative told us, "One time I officially complained and I got a written notice of the action taken". Another person's relative told us, "They responded to my complaint within 24 hours. I was invited in and provided with an action plan. I was very happy with the outcome". Staff were aware of the complaints policy and told us they would immediately help people to raise an official complaint if needed. The complaints procedure was clearly displayed in the service. This contained information on how to complain and where to go if the complaint was not resolved.

Inadequate

Is the service well-led?

Our findings

There was a 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. The registered manager handed in their resignation notice after the first day of the inspection. On the second day of our inspection a regional clinical lead led the home.

We asked people, their relatives and staff about their opinion on the management of the service. We received mixed feedback. One person told us, "I have a good relationship with the senior staff". Another person's relative said, "[The registered manager] is fine, I have no problem with things. The registered manager comes to see me". However, other people, their relatives and staff had a different opinion and told us that the standards of care had dramatically changed within the last year. One person's relative said, "'I have complained about the fact that when [person] first came in here there were more staff. It was a much better place. Gone downhill in the last year". Another person's relative remarked, "'Carers are very pleasant but I feel the people over them are not fit for the job. When it comes to making sure things are done, the care managers are not up to the job". Staff told us the quality of the service had changed in the past nine months as some staff had left and had not been replaced.

The culture of the service was mainly task focused which lacked attention to enhancing the daily lives of people and providing care which put the needs, wishes and choices of people at the core of how the service was run. Staff told us some of the nurses needed improvement in their attitude towards people. For example, some of the nurses were convinced that answering call bells was only the care assistant's role. They would often leave their office to find a care assistant to tell them someone needed assistance, instead of going to help the person, which would have taken as much time as coming to find the assistant.

Staff told us that the communication within the service was poor and sometimes they were left without proper guidance or support. A member of staff told us, "We are struggling with changing over to new care plans. There is no real guidance or overview to ensure consistency". Another member of staff said, "We are changing them (care plans) over currently. These take time to complete and we are still in the process of doing them. The registered manager did not give us much guidance on completing these".

We found at this inspection the quality and safety monitoring of the service to be ineffective at identifying where the quality and the safety of the service were being compromised. Even though the systems for monitoring care quality were in place, the concerns regarding people's nutrition and hydration, cleanliness of the place or staff shortages remained unnoticed and unaddressed by the management team. The results of the audits we looked at were contradictory and very confusing. For example, as a result of nutritional audit one person had a food and fluid chart in place which had been commenced the day prior to our inspection and was supposed to be carried out for one week. However, the daily audit from the first day of the inspection stated that none of the people in the service were on a food and fluid chart. We found the chart was discontinued on the first day of the inspection. The infection control audit was prepared by the

head of housekeeping, however, the infection control lead for the service was one of the nurses. There was no evidence of how they communicated the issues related to infection control in order to prepare an effective audit.

Records showed each of the units held regular staff meetings. However, the records showed the meetings were not supportive and they were not used to drive improvements to the quality of care in the home. We looked at the last three team meetings and found that staffing levels had been on the agenda of each of the team meetings. The issues remained unaddressed by the service. Instead, staff were left with the following instruction from the registered manager, "Please, think before booking appointments, look at your staffing levels and then book accordingly". There were also residents and relatives meetings organised by the service. People's relatives told us that they had raised the issues of the low staffing levels, however, the issues remained unresolved at the time of the inspection.

Records were not always available, accurate or complete. People's monitoring charts were incomplete and their grab files did not provide us with enough information on people's nutrition or repositioning. People's relatives told us that the recent record keeping was reduced to minimum. One person's relative told us, "They used to record what he had eaten for breakfast. Now it just says breakfast with no detail". Another person's relative said, "People themselves (staff) have a new system for notes. They check every so often but might as well be tick boxes. They come in to the room scribble and gone. They should go in and see if the person is alright".

There was a contingency plan in place which stated if one or two members of staff were absent and permanent staff could not cover their absence, then the vacancies needed to be absorbed into the shift. This meant that if the staffing on the day shift on one of the units was reduced, staff would not be able to meet people's needs. This would be just impossible to accommodate. We discussed this contingency plan with the regional director who told us this was not the provider's document and this procedure was introduced by the registered manager themselves. However, we were not assured if staff knew whether they were to follow this procedure or not. This contingency plan was immediately removed and replaced with the provider's plan which contained the contact details of all individuals available to support the home.

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

People were encouraged to provide feedback on their experience of the service. The survey organised by the service revealed a drop in satisfaction relating to activities (from 80% to 46%) and leadership of the service (from 92% to 71%). Even though the results of the survey had been published very recently, there was already an action plan in place. The planned actions included publishing the results in an easy-to-read format and meeting the heads of the departments to discuss results of the survey. Any improvements that needed to be implemented would be completed by the end of November 2017.

The service continuously analysed accidents and incidents in order to find a pattern and prevent the risk of their re-occurrence. We saw that actions had been taken to ensure people were safe after an incident had taken place. For example, some people had been referred to appropriate health care professionals which had helped to reduce the number of falls.

The manager understood their legal responsibilities and ensured that the local authority's safeguarding team and the CQC were notified of incidents that had to be reported and maintained records of these for monitoring purposes.

Following our inspection, the provider sent us a detailed action plan setting out how they planned to address the concerns highlighted by us during the inspection.

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 had failed to ensure that the care provided met people's needs and reflect their preferences.

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 Consent to care and treatment was not always sought in line with legislation and guidance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided to people in a safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems and processes in place to make sure they assessed, monitored and improved their service to ensure people received safe care. Records relating to the care and treatment for each person were not accurate and up to date.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People's needs were not met by sufficient numbers of staff and suitably deployed at all times to meet their personalised needs.

The enforcement action we took:

We served a warning notice that required the provider to become compliant by 1 December 2017.