Your Health Limited

Cedar Court Nursing Home (Dementia Unit)

Inspection report

Cedar Court Care Home
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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

We inspected Cedar Court Nursing Home (Dementia Unit) on 24 January 2017 and it was unannounced. It provides accommodation and nursing care for up to 50 people who are living with dementia. There were 42 people living at the service when we visited. There was separate all male accommodation upstairs in Bretby View and at the time of our inspection 17 men were living there. The overall rating for this service is Inadequate which means it will be placed into 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 service had did not have a registered manager. 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 provider had recently employed a new manager. They had been in a temporary clinical lead role for three months and had been moved to the permanent managers post for less than one week when we undertook the inspection.

At our last inspection we saw that the systems in place to monitor and improve the quality of the care provided to people were not effective. We asked the provider to set an action plan to make improvements across the home so that people received support which protected them from harm. They returned the plan in the specified time but it was not detailed enough and we received an amended plan on request afterwards. At this inspection we saw that the provider had not made significant improvement in meeting the actions on the plan and that the systems in place to manage the service were not effective. The provider had also not notified us of all of the events that they should to meet their registration.

Risks to people's health and wellbeing were not managed to keep them safe from harm. When people behaved in a way that could cause them or others harm this risk was not always assessed. Clear guidance

was not in place for staff to help people to manage this behaviour. When other risks were assessed the actions to reduce these were not always followed. People did not always receive their medicines as prescribed and the systems in place to manage the risks associated with them were not always followed.

When harm had occurred to people the circumstances around the incidents were not always thoroughly investigated or reported to the local authority to safeguard people from potential abuse. Staff did not always have the skills and experience to support people effectively to protect them from harm. They did not all receive the training and support they needed to do this. This meant that at times people were not treated with dignity and respect.

Some people had legally approved restrictions to protect them when they didn't have the capacity to make their own decisions. Some decisions had not been reviewed to ensure they were made in people's best interests. Some staff were not aware of these safeguards or what the restrictions were and therefore may not support them as defined.

Care was not always provided to meet people's preferences. Staff were not always aware of people's changing needs and records were not always amended to reflect the changes and ensure that the care was correct. Staff did not always have the experience and knowledge to support people effectively. People were not always supported to have enough to eat and drink and food was not always prepared to meet individual people's needs. They did not always have their healthcare needs met. There were not always communication systems in place to enable people to make choices. People's dignity was not always respected and they were sometimes supported in a manner which was not caring.

People were provided with meaningful activities and these were provided on an individual level as well as bigger events.

The provider had a complaints procedure in place and relatives told us that they knew how to complain. We saw that complaints were investigated in line with the procedure.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.
People were not protected from risk of harm because risk was not always assessed and actions agreed to reduce it were not always followed. People did not always receive their prescribed medicines and the systems in place to manage them were not effective. Incidents which could mean that people were at risk of abuse or harm were not always fully investigated or reported. There was a reliance on agency staff which meant they did not always have enough knowledge or experience to meet people's needs safely. Safe recruitment procedures were in place.

Is the service effective?

Requires Improvement

The service was not consistently effective.
Staff did not always receive the training and support that they needed to meet people's needs effectively. People were not always supported to have enough to eat and drink. They did not always have their healthcare needs met. People's capacity to make decisions was not always assessed or recorded.

Is the service caring?

Requires Improvement

The service was not consistently caring.
Staff did not always respect people's dignity. People were not always given the opportunity to make choices or retain their independence.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.
Staff were not always informed of changes to people's needs to ensure they received the right support. Records were not up to date and some contained confusing information. Activities were planned to stimulate people. Complaints were managed within the timeframes they had set.

Is the service well-led?

Inadequate

The service was not well led.
Systems were not always in place to measure and drive improvement. When plans were in place they were not completed. Some of the systems which should protect people

from the risk of harm were not effective. The provider did not ensure that information about significant events were reported.

Cedar Court Nursing Home (Dementia Unit)

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 visit took place on the 24 January 2017 and was unannounced. It was carried out by three inspectors. .

We checked the information we held about the service and the provider. This included notifications the provider had sent to us about significant events at the service and information we had received from the public. The provider had not completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However, we gave the manager the opportunity to discuss their plans for improvement at the inspection visit. We used this information to help us to come to our judgement.

We used a range of different methods to help us understand people's experiences. We spoke with five people who lived at the home about their care and support. We also spoke with relatives of four other people to gain their views. Most people were less able to express their views and so we observed the care that they received in communal areas. We spoke with six care staff, two nurses, the activity co-ordinator, the best practise lead member of staff, the kitchen manager and the manager of the home. We looked at care records for ten people and the medicines records for twenty four people to see if they were accurate and up to date. We also looked at records relating to the management of the service including quality checks, staff files and the service improvement plan. After the inspection we spoke with three social care and health professionals who worked closely with the home.

Inadequate

Is the service safe?

Our findings

At our last inspection we found that risk was not always managed to protect people from harm and there was a breach of Regulation 12 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. At this inspection we found that there had not been sufficient improvement to manage risk and people were not protected from harm.

We saw that some people behaved in a way that could cause them or others harm. Staff did not have guidance in place to describe how to diffuse these situations and this caused them to escalate or be repeated. For example, we saw one person becoming aggressive towards another person. Staff responded by walking them away and comforting them to help them to calm down. They did not put any actions in place to observe the two people or to ensure that they were kept apart. We saw that there were a further two incidents between them. One member of staff we spoke with told us, "That person does that sometimes and we just try to get them to calm down. There is no plan in place that I know of". We saw that staff had not considered what may be causing the person to become agitated or that receiving comforting staff interaction could be a consequence of their behaviour. When we spoke with staff to ask how they monitored the incidents they told us that they recorded them. We looked at records and saw that the three incidents had not been recorded. The staff we spoke with were not aware that this number of incidents had occurred between the two people which demonstrated that the systems in place to monitor people's behaviour were not effective.

Staff told us about other people whose behaviour could be challenging. We saw that one person had been assessed as being at risk of harm after some previous incidents between them and another person. There was a plan in place that staff should respond when the person left their room. We saw that they did this by going to them and asking what they wanted whenever they tried to leave their room and that the person usually couldn't say and went back to their room. When we looked at the records there was no guidance about supporting the person to engage with other people or to have some freedom to move about safely.

Some people were provided with additional support from staff on a one to one basis for long periods of time without guidance on how to plan the day to alieve the person's anxiety. We heard that when one person was distressed in their room that the member of staff working with them continued to insist that they received some personal care. When we looked at the guidance that was in place for staff to follow we saw that it was not detailed or descriptive. There were no records of the behaviours which analysed what could be causing the person to behave in this way. This demonstrated to us that when people's behaviours could cause harm they were not always risk assessed. We saw the guidance was not always clear or in place to support staff to assist people to be calm, and that incidents of behaviour were not always recorded to allow analysis of triggers and trends.

Some people had been assessed as being at risk of choking and had been recommended a specialist diet to prevent this from happening. When we spoke with the kitchen manager they told us that they did not prepare food especially in this way and would rely on staff who were supporting people to ensure it was done. When we spoke with one relative they said, "Today's meal is liver and mash and so I have requested a

jacket potato for my relative because liver is too tough to mash". When we spoke with staff in one dining area they were not able to say who had been assessed as being at risk of choking and told us that they relied on the list which was sent to the kitchen. When we looked at the list it was not up to date and did not include this specialist diet, and only recorded if someone was diabetic or required puree food. This showed us that some people were not being provided with food in the format which would ensure that the risk of choking was reviewed.

Other people were assessed as needing to drink a certain amount of fluids to maintain their health. Staff we spoke with were unable to tell us how much they should drink One member of staff said, "I don't know how much they should have. I just offer the drink and then record what they take". We looked at records and found that some had not been completed, others were unclear and there was no direction of the total quantity that someone should drink. This showed us that we could not be confident that the provider had systems in place which ensured people's health was maintained by drinking enough fluids.

When we reviewed care plans and the daily records we found that they were often not updated to reflect the person's current needs. There was information in one record which had not been transferred to the others and this meant that on some occasions risk had not been managed. For example, one person was assessed as being at risk of damage to their skin because their weight had reduced. They should have been referred to a health specialist to review this but the referral had not been made. Another person was receiving treatment and when we reviewed their care plan it stated that a specialist diet would assist them to recover. This had not been implemented and they were not provided with this meal.

At our last inspection we saw that medicines were not always well managed and at this inspection we found that improvements were still required. One person was prescribed medicines to take when needed (PRN) which would help to calm anxiety. The guidance in place for staff did not describe a clear strategy for administration. It said, 'Use for increased shouting or aggression to staff'. We saw that when the person had taken this there was no record to explain why it had been administered. We were told that the person had taken this medicine on the day we visited but when we looked at the Medicines Administration Record (MAR) it had not been signed. When we checked the numbers of tablets that should be stored we found that there were less than there should have been. This meant that we could not be certain that the person had received the medicine to meet their assessed need, or have confidence that it had been administered correctly.

Another person was prescribed medicines to manage a condition. When we spoke with the manager they confirmed that it was important that these medicines were administered at the prescribed time to help to manage the symptoms. When we checked the MAR the medicine had not been administered at the correct time. This meant that we could not be certain that this person received their important medicine at the time that they needed it. One person's relative told us, "It is important that my relative takes their tablets at the right time but sometimes they refuse them. I am worried about what will happen if they do". When we checked the person's care plan there were no strategies recorded to help support them to take their medicines in distressed situations.

Some people who were living with dementia were prescribed as and when required medicine known as PRN medicines for pain management. There was no guidance for staff to assess if the person was in pain and when to administer pain relief. Other people had PRN medicines to help to calm them when distressed and there was limited guidance available for staff. When PRN was administered the MAR was not completed to record why it had been given so that the person's wellbeing could be monitored. This information was particularly important because there were agency staff managing medicines who were not as familiar with people.

Some people were prescribed PRN topical creams to treat or maintain skin integrity. We saw instructions were unclear for where and when this should be applied. One member of staff we spoke with said, "We would apply it if we were instructed to by the nurse. It is usual to apply the cream after the person has a shower". When we reviewed the MAR we saw that it had not been administered on a regular basis. This meant that we could not be certain that the person was receiving topical cream when they needed it. .

We reviewed the systems which were in place to manage risks associated with medicines. When we checked the medicines stock we found that the amount recorded was incorrect for two of the eight reviewed. We looked at eight topical creams and saw that dates of opening were not recorded on two of them. When we checked three packets of medicines we saw that the date of opening had not been recorded on two of them. One of 24 MAR sheets had people's allergies recorded on them and only ten recorded how people preferred to take their medicines. This demonstrated to us that the provider was not meeting the standards set by the Nursing and Midwifery Council for the management of medicines in nursing homes.

We saw that MARs were not signed on three occasions and we could not be confident that people had received them as required. When we checked stocks of medicine they were not always correct and although they were only three days into a new medicines cycle there were three missing important medicines from one stock check. There were no PRN protocols in place and no record of why people had received medicines. This had a greater impact because there were a lot of agency nurses working in the home and care records were not always up to date.

This evidence represents an ongoing breach in Regulation 12 (1) of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.

People were not always protected from abuse and avoidable harm. When we spoke with staff about specific incidents they did not always recognise them as potential safeguarding concerns. For example, we saw that one person had bruised hands. They told us that the bruising had been caused by banging the wall and the door. When we asked staff they confirmed that this was normal behaviour for them. Staff had not recognised that it put the person at risk of harm and no action had been taken to resolve this behaviour.

Some people spent all day in their rooms. One member of staff told us, "[Name] shouts and is verbally aggressive in the communal area and they disturb other people and so it is better for them to be in their room". This meant that this person spent the full day in their room under continuous supervision from staff. This was a deprivation of their liberty and had not been legally approved. Other people had alarms on their doors which meant that when they left their room staff went to them so they had very little opportunity to walk around freely. The provider had not considered whether these were the least restrictive practices or potential safeguarding concerns.

Staff described what they would look for to recognise abuse and how they would report safeguarding; however, behaviour that we considered harmful were not recognised as unusual or in need of reporting. When we discussed one person's behaviour which could harm themselves or others with a member of staff they said, "That can happen on a daily basis, it is regular here". We saw that records were not always maintained of incidents which meant that there would be no analysis of recurrence. One healthcare professional we spoke with said, "The quality of recording is not always detailed to be able to investigate how injuries occurred. Some staff have not taken safeguarding concerns seriously". This showed us that information was not recorded so that staff could report incidents in line with safeguarding guidelines.

This evidence represents a breach of Regulation 13 (1) and (4) of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.

At the last inspection we saw that there were not always enough staff to meet people's needs. At this inspection there were more staff deployed across the three communal areas to ensure that people's needs were met. However, a lot of the staff were not permanent and were employed through a recruitment agency. We saw that in some areas of the home this meant that the staff who were supporting people did not know them well, and could not always respond to their needs in a timely manner. It also meant that there was not always a clear plan or leadership to meet people's needs. For example, we saw that during a mealtime staff were supporting people to receive their meals. One person became restless and caused some distress to others and staff reacted by trying to distract them. After the other people had eaten and a permanent member of staff returned to the dining room they realised that this person had not received a meal. One relative we spoke with said, "There has been a lot of change and we have lost a lot of staff who knew [name] well. The agency staff don't know them and I sometimes don't think my relative is safe". One health professional told us, "There are issues at the moment because a lot of the long term qualified staff have left and there are issues around leadership and communication. We are often asked to review people we have already seen because information hasn't been shared". This showed us that people were not always supported by staff who had the right mix of skills and experience to meet their needs safely.

Staff confirmed that recruitment checks were completed to ensure they were suitable to work with people when they first started. These checks included requesting and checking references of the staffs' characters and their suitability to work with the people who used the service. We looked at records and spoke with a member of staff who had recently started working in the service. They told us the provider had received references and a police check had been carried out to ensure they were suitable to work with people before they started work.

Requires Improvement

Is the service effective?

Our findings

People were not always supported by staff who had the skills and knowledge to meet their needs. The home was providing support to people who were living with dementia; and some people became anxious and distressed and behaved in ways which could cause harm to themselves or others. We saw that staff did not always know how to support people to avoid these behaviours or to manage them. Staff we spoke with said, "I would like training in challenging behaviour because we have not done that". Some of the staff we spoke with had not had experience of working with people with dementia and had not received training in it. We saw that staff were not always equipped to meet people's needs because they didn't know how to diffuse situations and they didn't know about people's lives to be able to engage with them when they were talking about past events. One health and social care professional we spoke with said, "We have highlighted to the provider that the strategies for managing people's behaviours that may challenge need to be developed. We have also suggested that they need to provide training to support staff to understand dementia and to manage behaviours that may challenge". When we spoke with the manager they said, "We have had a very high turnover of staff this year and it means that we have relied on agency staff and have recruited some new staff and are continually trying to recruit more. We recognise that we need to upskill the new staff". We asked one member of agency staff who was providing individualised support to one person about training. They told us that they had a basic induction but had not received any further training or competency checks. They were supporting someone who was at high risk of falls and could become distressed and angry at times. This showed us that the provider had not ensured that all staff had the skills and support to ensure that people's complex needs were met.

Staff we spoke with were not always able to explain to us how people were supported to make decisions. They stated that they knew that the Mental Capacity Act 2005 (MCA) was about people's rights but could not tell us how best interest decisions were made for people who did not have capacity. When we discussed some people's care with the staff they told us that the arrangements were what the family wanted. They were unable to say if the family had the legal responsibility to make that decision. Some staff were not able to tell us who was protected under a legal safeguard or how they tried to ensure that support was not restrictive. This demonstrated that staff were not always knowledgeable about the MCA to support people within the legal framework.
This evidence represents a breach of Regulation 18 (2) of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.

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 or themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We looked at how the provider was meeting the requirements of the MCA. We saw that some capacity

assessments had been completed for some people when they were not able to consent to decisions about their care. They referred to generic situations such as receiving care and living in a building which was secure to protect people from harm. There were no assessments in place which showed when particular decisions had been considered; for example, the decision was made to move one person into a different part of the home without first considering their capacity to make the decision. Some people had decisions about longer term care in place such as Do Not Resuscitate orders. These decisions were not supported by a capacity assessment. Some people had DoLs approvals in place to ensure that any restrictions on their freedom were approved; and further applications had been made. We found that these did not cover all of the restrictions that were in place for some people.

People were not always supported to have enough to eat and drink. Food was not always suitable to meet their needs. For example, one person was given a meal which they were unable to eat because it was too liquid. The member of staff who was supporting them told us, "This dessert is no good for them and I will get something else. They do much better with cakes and biscuits". Other people sat at the table and did not eat very much; staff did not sit with them to assist or encourage them. Some people did not sit at the table for long periods of time and preferred to walk throughout the meal. The food was not suitable to eat with their hands and so they did not eat very much of it. This showed us that food was not planned to meet people's needs and that the provider had not given consideration to providing food that people living with dementia may find easier to eat.

The meal time experience was not always well planned and some people did not receive their meal at the correct temperature. In one dining area the food was served from hot trays without any equipment to maintain the heat. It took over forty minutes to serve each person in the room and by that time the food was no longer warm. Some people were offered a choice of meal but there was no adaptations in place to assist people who could not say what they wanted. People did not have a choice of dessert. There was no menu for people to know what their meal was and not all people were offered condiments on the table.

People did not always have their health care needs met. One relative we spoke with said, "I know my relative sees a doctor when they need to but they have not seen a dentist in a couple of years". Another relative said, "We have not had any contact from a specialist healthcare professional since we moved here and I would like them to see my relative". One healthcare professional we spoke with said, "We are asked to visit people when they are unwell but sometimes it is not very organised. We may visit people who we have already reviewed and then when we are there recognise other people who require our attention". Some people were assessed as requiring specialist healthcare support but the referrals for this had not been actioned. When we looked at records which were monitoring people's health we found that they were not always complete. This meant that we were not assured that the provider had systems in place to monitor and meet people's healthcare needs.

Requires Improvement

Is the service caring?

Our findings

People were not always supported in a manner that was caring or promoted their dignity. We saw that when staff were trying to support people to manage their anxiety or distress they sometimes spoke to them in a manner which was not respectful. For example, people were sometimes reprimanded for the language that they used or told that certain actions were naughty. This demonstrated to us that staff were not always equipped to help people who were living with dementia in a way which respected them.

We saw that when staff were rushed or trying to manage situations that this also impacted on the way that they interacted with people. One person was being supported by a member of staff to eat their meal and when another person became distressed this impacted on their mealtime experience. The member of staff stood over the person they were supporting while they helped them to eat whilst talking to another person. They then left the person half way through the meal without explaining leaving them with the person who was distressed. When they returned they continued to support the person while speaking to another member of staff. This showed us that when the provider did not have clear strategies to help staff to support people to manage their behaviours it impacted on the quality of care that other people received.

People were not always enabled to be independent. For example, the provider had not considered that some people could eat independently if they did not need to use cutlery and they had not provided food or snacks in a different format. This meant that they relied on staff to support them and that they may need to wait for that assistance. The environment in Bretby view meant that people could not always move about independently because it was small and contained.

Some people did not always have their dignity upheld. We saw that some people were not smartly dressed; for example, three people wore outdoor heavy shoes without socks. One person wore a heavy, soiled clothes protector when they were not eating a meal.

We saw that at other times staff were kind and caring. For example, we saw staff holding people's hands and talking with them when they were distressed. Some people had been supported with their appearance and wore jewellery and had favourite personal items with them. There were celebrations for people on their birthdays and art work that they had completed was displayed on the wall.

We saw that people were asked about choices at times; for example, what they wanted to eat. However, a lot of people were not able to make verbal choices and they were not supported to make choices in other ways; for example, through photographs or pictures.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we saw that the provider was not always responsive to people's needs and that care plans were not always up to date. At this inspection we saw that the required improvements had not been made. Staff did not always know what people's up to date care needs were. For example, we saw that one person had a bruise to their head. When we asked two staff how this had happened neither of them could tell us. They said that they had not worked with the person for a few days. The records we saw did not always have up to date information in them. One healthcare professional told us, "When we visit to review people their records are not always clear and sometimes the information is on a bit of paper rather than in the person's care plan".

We saw that people had two care plans and that one was for everyday use. However, when we looked at both plans we saw that the information in the two plans was not always the same. For example, for one person one file stated that they could stand independently and another said that they required the use of equipment to be safe. This meant that staff could provide the incorrect support to this person.

We found that information was not easily accessible. One person took their medicines covertly. This means that they were not aware that they were there and they may be hidden to ensure that they take them. This approach must be approved by a medical professional and be reviewed. We found some of the information in the MARs and some of it in the care plan in correspondence. This showed us that the provider had not ensured that there was a clear plan in place which was accessible to the member of staff administering medicines to ensure that they had authorisation to do so.

Information was not available about people's personal histories. We saw that one other person was talking to staff about their previous employment. The member of staff was unable to tell us what the person's job had been. The person became frustrated and did not carry on speaking. This meant that staff did not have the information they needed to help people living with dementia to talk about their past and avoid social isolation.

At the last inspection we saw that some of the environment did not support people living with dementia because it did not have signage to help them to orientate around the home. We saw that the provider had made some improvements in the environment, however further improvements were required. There were pictures and photos on the walls and on people's doors to help them to know what rooms were for. One communal area had been altered so that people always had access to a smaller quieter space and could also eat their meals there. They had been provided with items which could stimulate conversation and interaction such as old fashioned toys.

The people living in Bretby View were not free to move about the environment because there was only one corridor that they had access to and there was little space to move about. This meant that sometimes friction was caused between the people living there when they bumped into each other or knocked each other's belongings. This meant that not all of the accommodation had been reviewed to ensure that it met people's needs.

At our last inspection we found that people did not always have access to meaningful activities and at times were left without stimulation for long periods of time. At this inspection we saw that the provider had made improvements and that people had opportunities to play games and or had access to sensory, therapeutic items to stimulate them. There was an activity co-ordinator who was employed to devise a programme of activities as well as think about individual needs. They told us, "Each person has an activity book and part of my role will be to ensure that all staff know what people like and how to engage them. We are developing that as new staff join the team". One relative we spoke with told us, "I have come in and done some singing for the residents and they seemed to really enjoy it; lots of people remembered the words to songs". Another relative said, "The activity co-ordinator suggested things we could try with [name] and has given us some bits. Sometimes they will look at books if they are in a calm mood".

The provider had a complaints procedure in place and relatives told us that they knew how to complain. One relative said, "I have raised concerns before and they are responded to". The manager told us about the complaints they had received and we saw how they were being responded to within the company policy.

Inadequate

Is the service well-led?

Our findings

At the last inspection we saw that the systems in place to measure and drive improvement were not fully effective and required improvement. At this inspection we saw that further improvements were required to ensure that the service was well managed. The provider had produced an action plan after the last inspection which demonstrated how they would meet the breaches in the regulations we had identified. At this inspection we found that these actions had not been completed.

The systems which were in place to audit the safety and the quality of the service were not adequate. We saw that risk assessments were not up to date, reviewed or fully shared with staff providing care. Care plans were not always up to date and at times contained conflicting information; for example, we saw that there for one person one file stated that they could stand independently and another said that they required the use of equipment to be safe. The care plan audit did not analyse the quality of the information contained in the plan. This meant that staff did not have up to date, clear information to meet people's needs safely.

There was an action plan to improve medicines management. We reviewed the actions on this plan against our findings and found that actions which were due to be completed had not been. For example, staff should have reviewed any gaps in MARs at the end of the medicines round. We saw that this had not been completed and identified two gaps from the day that we visited in MARs recording. This showed us that the provider had assessed where there were concerns but had not implemented adequate systems to manage them which put people at risk of harm.

Some people had Do Not Resuscitate orders in place which were not fully completed or were not up to date and these had not been reviewed. The provider was aware of this but had not taken immediate action to amend them. This meant that people's choices may not be followed in an emergency by healthcare professionals.

At our last inspection we said that the provider needed to improve their infection control and environmental audits. At this inspection we saw that this had not been immediately implemented and was only actioned after several infection outbreaks. Healthcare professionals supported the provider to implement an action plan to address the assessed concerns. Action was taken which included replacement of a substantial amount of bedding and furniture. This showed us that the provider did not take adequate action when the concerns about the environment were first raised and did not implement a thorough environmental audit and refurbishment until there were outbreaks of infection.

Staff did not have a thorough understanding of situations which could cause harm to people and when they should be reported as safeguarding concerns. When safeguarding concerns were identified the provider did not always take immediate action to ensure that the risk of harm was reduced. For example, when one person had unexplained bruising the provider did not review the environment to assess if there were hazards in their room or review their plan to ensure they were able to be moved safely. One social care professional we spoke with said, "At times it has been difficult to speak with staff to investigate safeguarding concerns. We have asked for responses from the provider as well which have not always been completed

immediately". This meant that action was not always taken to protect people from harm.

There had been a high turnover in staffing in the past year. Staff did not always receive regular support and supervison to ensure that they were competent to support people effectively. One member of staff we spoke with said, "I haven't had a supervision for some time". We spoke with the manager who confirmed that supervisions had not been taking place. They told us, "We have relied on agency staff a lot and have tried to put structures in place to ensure we have regular people. However, it has made it difficult to implement some of our plans and we are still recruiting heavily. I have started to have staff meetings and plan to start supervisions. It is important moving forward that I develop an empowered confident team".

The provider had not used feedback from people who used the service or their relatives to improve the quality of the service. One relative we spoke with said, "I think I was sent a survey but I didn't fill it in because I don't feel as though anything would change. They have never been acted on". Another relative said, "They did put one meeting on recently but it was more to tell us who the new managers were than to ask us for our ideas. I have raised that we need a water station upstairs because there is only one tap that gives drinking water but it hasn't been done". Relatives we spoke with described the anxiety that they had felt when they were unable to visit their families because the home closed to contain contagious infections. One relative said, "I come every day to make sure that [name] is okay and was really worried about them. The home has not let us know what actions they have taken to make sure that it doesn't happen again". When we spoke with the manager they recognised that this was an area that needed to be developed.

The provider had an action plan in place with the agencies who contracted services from them. They had not met this action plan across three reviews, spanning several months and there were concerns that further issues were being highlighted at each review visit. One social care professional told us, "The action plan has not been implemented and we have had some concerns about the urgency that some of the serious concerns we had have been addressed. For example, we raised concerns that the information in care plans was not up to date in September 2016 and that it was particularly urgent because of the reliance on agency staff who were not as familiar with people. When we re-visited in January 2017 we found that there had been no significant progress against this action".

This evidence represents an ongoing breach in Regulation 17 (1) of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.

To comply with their registration requirements the provider must send us notifications about important events which happen in or affect the running of the home. The registered manager had left the service and we had not been notified of this change. We alerted the provider prior to the inspection visit that the previous manager was still registered with us as the manager and they did not take immediate action to remedy this. At the time of the inspection visit the provider had not taken action to resolve this situation.

This evidence represents a breach of Care Quality Commission (Registration) Regulations 2009: Regulation 15.

We were also made aware of other important events that the provider had not notified us of. These included notifications about safeguarding concerns and serious injuries. It is important that we receive this information to enable us to continually monitor the safety of the people who live at the home.

This evidence represents a breach of Care Quality Commission (Registration) Regulations 2009: Regulation 18.

The provider had recently appointed a new manager. They recognised the concerns that we highlighted and discussed at length the plans they had to resolve them. Staff we spoke with told us that they felt supported by the manager and felt confident that they would be listened to and included in future developments. The manager had made a commitment to work closely with partner agencies to implement the action plans and drive quality improvement.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given. It is also a requirement that the latest CQC report is published on the provider's website. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating in their reception and on their website.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 Registration Regulations 2009 Notifications – notices of change Notifications about change in registered manager were not completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents Other notifications about safeguarding incidents and serious injuries were not completed.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way to protect people from harm.

The enforcement action we took:

Impose a condition on the registration to ensure that actions are taken and reported to meet the required regulations.

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 People were not always protected from abuse and supported in the least restrictive way to protect them from harm.

The enforcement action we took:

Impose a condition on the registration to ensure that actions are taken and reported to meet the required regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes did not effectively ensure compliance with the regulations.

The enforcement action we took:

Impose a condition on the registration to ensure that actions are taken and reported to meet the required regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not always provided with the support, training, professional development, supervision

Diagnostic and screening procedures

Treatment of disease, disorder or injury

and appraisal to ensure that they could fulfil their roles effectively.

The enforcement action we took:

Impose a condition on the registration to ensure that actions are taken and reported to meet the required regulations.