Mr & Mrs BN Patel

Cedars Residential Care Home

Inspection report

Sudbury Road
Halstead
Essex
CO9 2BB

Tel: 01787472418

Date of inspection visit:
29 November 2016
30 November 2016

Date of publication:
28 March 2017

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

The inspection took place on 28 and 29 November 2016 and was unannounced.

At our inspection on 25 and 28 June 2015 we found that the service required improvement and was rated Inadequate with regard to its safety. At our last inspection on 6 and 28 July 2016 we found that the service had not made the required improvements and was in breach of eight regulations. We made requirement actions for these breaches, rated the service Inadequate and placed the service into Special Measures. Services in special measures are kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, are 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.

At this inspection we found that, although some improvements were evident, the required improvements had not all been put into place and our concerns about the safety and effectiveness of the service remained. The overall rating for this service remains 'Inadequate' and the service therefore continues to be in special measures while we consider our regulatory response which, in line with our enforcement policy, may lead to taking action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Risks were assessed and documented in care plans but staff did not always manage risks effectively and people were not always safe. We continued to see practices which placed people at risk, including poor moving and handling techniques.

The provider did not have sufficient oversight of the safety of the service and risks were not effectively monitored. The service was not always proactive in managing the risks related to the prevention of pressure sores for people with limited or no mobility.

Infection control measures were in place and concerns highlighted by our previous inspection had been addressed.

There were not always enough skilled and experienced staff to meet people's needs promptly. There was a

lack of strategy in place regarding the deployment of staff. There was a recruitment procedure in place but the skills and experience of staff was not clearly established and verified before employing them. Staff received an induction and the training they needed to carry out their roles but staff practice did not always demonstrate that they put this learning into place.

Staff were trained in safeguarding people from abuse and the manager referred incidents appropriately to the local authority safeguarding team for investigation.

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

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

People who used the service praised the food and people were referred to dieticians if they required this. Support at mealtimes for people who needed help or encouragement to eat and maintain their weight varied and in some cases was poor. Oversight of people's nutritional needs and recording related to this was not always good, although some improvement was evident.

Some staff were very caring and treated people respectfully, ensuring their dignity was maintained. Others were less caring and did not consider people's dignity and comfort.

People were involved in planning and reviewing their care but this was not always evident for those people with significant needs related to their advanced dementia.

People were not supported to follow a wide range of hobbies and interests. People living with dementia and those unable to go out independently lacked stimulation and most people were not meaningfully occupied. Staff understanding of the needs of people with dementia was poor.

A complaints procedure was in place but records did not always show how issues raised were followed up or actions taken.

Staff felt they were well supported by the management team and found them approachable.

Systems designed to assess and monitor the quality of the service were in place but were not always effective. The provider had oversight of issues affecting the service but did not have an effective management system in place to bring about the required improvements and motivate and manage the staff to deliver these.

We found several continued breaches of regulations during this inspection. We have also shared our concerns with the local authority contracts and quality and improvement teams.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were not enough skilled and experienced staff and staff were not always deployed in a way which ensured people were safe and their needs met promptly. Staff recruitment did not include diligent checks to verify that staff had the required skills or were able to learn them.

Risks were assessed but staff did not always manage risks appropriately, particularly those related to pressure care.

The service was clean and there were now systems in place to limit and control the spread of infection

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

Is the service effective?

Requires Improvement

The service was not effective.

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

Staff received training but their understanding of some aspects of care was not good.

People were positive about the food but people's eating and drinking was not adequately monitored.

People were promptly supported to access healthcare professionals when they needed to but staff did not always follow guidance related to people's health.

Is the service caring?

Requires Improvement

The service was not always caring.

Feedback from people who used the service and relatives was positive about the kindness and patience of the staff but we observed that not all staff were caring and patient.

People's privacy and dignity was not always maintained.

People, or their relatives, were mostly involved in making decisions about their care.

Is the service responsive?

Requires Improvement

The service was not responsive.

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

Person centred care for those living with dementia was poor and people lacked stimulation and occupation unless they were independently able to access this.

A complaints procedure was in place and informal issues were able to be raised, although actions taken to address concerns were not always clear.

Is the service well-led?

Inadequate

The service was not well led.

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

Although staff felt well supported by the management team, they did not always demonstrate accountability and responsibility. Poor staff practice was recorded but disciplinary procedures did not bring about improvement.

Audits designed to assess and monitor the quality and safety of the service were in place. The manager had oversight of the issues at the service but did not demonstrate an ability to support, motivate and manage the staff to deliver required improvements.

Cedars Residential Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 28 and 29 November 2016. The inspection on 28 November was an out of hours inspection starting at 20.00. Both inspections were unannounced.

The inspection team on 28 November consisted of two inspectors. On the 29 November it consisted of two inspectors and an expert-by- experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert had experience of services for older people and of dementia care.

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

We spoke with ten people who used the service, three relatives, one visiting professional, two senior care staff , five care staff, an agency staff member, the administrator, the deputy manager and the registered manager. We observed staff providing care and support and we used the Short Observational framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not communicate with us easily. Following the inspection we contacted staff at the local authority quality and improvement team.

We reviewed eight care plans, seven medication records, three staff files, staffing rotas for the six weeks leading up to the inspection and records relating to the quality and safety of the service and its equipment.

Inadequate

Is the service safe?

Our findings

At our last inspection on 6 and 28 July 2016 we found the service to have breached the regulations with regard to the safe management of infection control, staffing levels and the skills and expertise of staff. At this inspection, although there were fewer concerns related to infection control, we remained concerned about staffing and the management of risk.

We saw that risks, such as those related to moving and handling, choking and a person's risk of falling, had been assessed and actions to reduce these risks were well documented in care plans. Plans had not always been appropriately updated and did not reflect people's current needs which placed them at risk, especially if a new or agency member of staff was relying on the accuracy of the information. For example one person, whose risk assessment had been last updated on 20 October 2016 and signed by staff, had a plan which stated that they enjoyed 'pottering about' the service and could stand independently from a chair. This was not seen in practice and we observed the person struggling to stand up. They had fallen on the morning of the inspection.

People's risk of falling was not well managed. Records were conflicting and gave staff and other professionals an inaccurate picture. One person had had a fall on 6 March 2016 but the review dated 17 March stated that they had had no recorded falls. Similarly in August, October and November no falls were recorded when in fact the person had fallen.

Another person was observed to be very unsteady on their feet when transferring from a chair to a wheelchair. Staff struggled to prevent the person from falling to the floor. A senior member of staff told us that sometimes the person can manage well, but we observed that staff did not appear to be well prepared for occasions when the person's mobility was poor. The staff member told us that the person managed best when supported with their manual handling needs by two male carers, presumably due to their increased physical strength. Asking male staff from another part of the service did not appear to have been considered on this occasion.

We noted poor and unsafe moving and handling techniques demonstrated throughout our inspection. We observed several occasions when people were pulled up from chairs from under their arms. This manoeuvre places people at risk of damaging their shoulder joint. We also observed three staff, including one senior staff member, attempting to hoist a person into their wheelchair. Staff did not demonstrate expertise in this manoeuvre and the person was hoisted up and back down into the chair several times. The manual handling sling was not put on properly and caught on the chair, it was then removed and reapplied and further adjustments made which were clearly uncomfortable for the person concerned. In total the manoeuvre took more than ten minutes. This meant that we were not assured that staff were sufficiently skilled in safe and effective moving and handling techniques.

Risks from the environment, which we identified at our previous inspection, had mostly been reduced. Keypads had been introduced on the main kitchen doors and on those of the smaller kitchens. However we noted that the main kitchen door was wide open when we arrived at the service for our evening inspection

visit on 29 November. This continued to place people living with dementia at risk.

New mops and buckets had been purchased and a system introduced to ensure mops were colour coded to signify that they were only for use in particular areas of the service. We observed staff clearing up a spillage in one of the lounges and using the correct equipment. However they did not give any thought to the additional risk a wet floor posed to people who used the service and staff. Other risks related to infection control we identified at the last inspection had also been addressed and new flooring was laid to replace stained carpet and the kitchen, kitchen equipment and staff areas had been cleaned. We did note that some areas of the kitchen could benefit from further cleaning, such as where parts for the mixer were stored as this was not in a clean state.

We also identified some new environmental risks at this inspection. Some fire doors had been propped open, including one to the main stairwell on Meadows. This increased a heightened risk of any fire spreading from one floor to another. Before we carried out our inspection we had been informed that the service's hoist was not working properly and staff were having to insert a pen in the mechanism as a wire was loose. This was not safe practice. We saw that the fault had first been noted on 16 October and an engineer had recommended the purchase of a new handset on 27 October and stated it was safe to operate. Staff confirmed that the hoist had been in use in the intervening period.

Our previous inspection identified that people's risk of developing a pressure sore was not being well managed. At that inspection we observed people again sitting for several hours without a change of position. Although the registered manager told us that they had had no incidents of pressure sores at the service we still found that people with an identified risk of developing a pressure sore were not being adequately repositioned. For example records showed that one person, whose care plan stated they should be repositioned every two to three hours, had no record of being repositioned between 12.30 and 20.10 on the day of our inspection. On the previous day they had been repositioned at 06.00, 11.20, 18.00 and 21.10. Another person had a similar record and had been repositioned the previous day at 06.00, 11.10 and 19.50. These times mirror what we found at our previous inspection.

We asked one senior member of staff how often a person, whose care plan says they should be repositioned every two hours, should have a change of position. They told us, "After lunch [they have] two hours bed rest". This did not match the care documented in the care plan and placed this person at risk of developing a pressure sore.

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

People who used the service were mostly accepting of the staffing levels and waited patiently for support. We observed a person calling out for staff. A member of staff replied, "Yes" but did not go over to the person who had not heard their reply. The person then said, "I think that the nurse has gone home". Another person said, "Bless them, they do their best. They do what they can do".

Staff were very busy throughout the shift and we saw that most stayed on at the end of their shift as they had not finished all their tasks. We observed a senior member of staff putting verbal pressure on another staff member when asking them to stay later when they had already done an eight and a quarter hour shift. Staff regularly did 14 hour shifts and we saw that some staff were working many days without a day off. One staff member worked 20 days in a row and others 13, including one night staff member. We tracked three members of staff over a six week period and found that they were all working in excess of 53 hours a week. Given that we observed staff to be constantly occupied during their shifts we concluded that such hours

could contribute to staff being more at risk of making mistakes.

Staffing levels and the deployment of staff continued to be a primary concern, along with concerns relating to the skills and experience of staff. We noted that staff were very careful on Meadows to ensure that there was always a member of staff on duty in the main lounge so that people were never left unattended. However sometimes the only staff member in the lounge was an agency staff member who told us they did not know people at all and had not received an induction. In the main lounge we observed that people were without any staff support for a period of nine minutes while staff offered support elsewhere. Call bells were answered promptly during our inspection but a review of call bells showed that some calls were not answered for over seven minutes.

Although rotas demonstrated that the service was operating within the levels they had assessed as being safe, we noted occasions where people had to wait unacceptable amounts of time for support. For example, an agency staff member noticed that a person required changing as they had been incontinent. They alerted the senior member of staff who was on duty with them at 21.20. The senior member of staff left the lounge area to carry out other chores. At 21.55 we asked the senior staff member why they still had not provided the person with the support they required. They told us that they needed an additional staff member to come over from the other part of the service before they could do this. This member of staff finally arrived and the person was supported to go to get changed at 22.30. This was an unacceptable delay and did nothing to safeguard the person who had an identified risk of developing a pressure sore. This practice also failed to maintain this person's dignity and comfort.

When we undertook our evening inspection on 28 November we found that staffing levels included some agency staff who were not all familiar with people's needs. For example an agency staff member was working alone in the lounge and we observed a person, who had had a fall earlier in the day, attempting to stand up. They were very unsteady on their feet. The staff member had not attended the handover meeting and was not aware that they had had a fall earlier and needed to be more closely monitored. They made no attempt to help the person or try to reduce the risk of them falling again.

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

Staff employed at the service had been through a recruitment process before they started work, although checking of references was basic in some cases. Permanent and agency staff recruited on long term placements had checks in place from the Disclosure and Barring Service to establish if they had any criminal record which would exclude them from working in this setting. No structured interview had taken place for some staff to establish if they had the skills and competence to carry out the role. This was also an issue at our previous inspection. However a newly introduced recruitment procedure documented that a brief face to face interview had taken place for some newly employed staff.

We noted that one staff member demonstrated a very poor level of spoken English and was not able to tell us the numbers for the keypads on the doors. We observed this member of staff struggling to be understood and failing to understand people who used the service when they spoke. This person's recruitment file stated that they had intermediate English but there had been no interview or further consideration of the possible impact of this language difficulty. Staff recruitment was still not entirely robust and did not ensure people were suitable for the position they were employed for.

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

Medicines, including controlled drugs, were stored securely, in a suitable environment, and were monitored appropriately. Records showed that people received medicines when they needed them, and there was guidance for staff on when to administer medicines intended to be given as and when needed, for example for pain or anxiety.

Staff received training in the administration of medicines and we observed medicines being administered and found staff to be competent. There were robust procedures in place for the ordering, administration, stock control and disposal of medicines. We checked the stocks of eight medicines, including controlled drugs, and found these tallied with records. There was clear information about current medicines available for staff to refer to.

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

Requires Improvement

Is the service effective?

Our findings

Most people living at the service were living with a degree of dementia and some were not able to speak with us about the service. Those who could had a range of opinions about the service and about the way staff cared for them. One person said, "The staff are good and polite". Another said, "They look after me well". Other people commented in a neutral manner commenting for example, "It's alright". One person was very negative saying, "I just want to get home out of this evil place". One relative was very complimentary about the way staff kept them informed about their relative's complex health conditions and said, "They are very good with [my relative]".

People who use the service were reasonably happy with the food although some expressed negative comments about the choice available. One person said, "I don't go much for the food really". Menus were written on blackboards but these were not easy for people to read. There were no photographic menus for people with dementia to refer to. The lunchtime experience differed in the two separate sides of the service. On Meadows the lunchtime experience was positive and we observed staff supporting people to eat their meals sensitively and without rushing them. Choice was promoted and we saw staff going to great lengths to provide acceptable choices for one person who kept refusing. A number of options were tried and staff showed great patience. We saw that where people required food to be pureed this was provided for them in an attractive manner. Drinks on this unit were well promoted throughout the day.

We saw that a member of the domestic staff came to assist people at lunchtime. They told us they did this regularly and they worked sensitively and very well. Although we were not in any way concerned by their practice we noted that they had not been given any training related to nutrition which may have enhanced their skills and ensured they were fully aware of people's risk of choking.

The lunchtime experience in the main house was more of a mixed picture. People were brought to the dining tables and then had to wait up to 45 minutes for their meals. Five people ate nothing during lunch. We observed one person who was unable to cut up their food but staff did not notice. At one time there was only one staff member in the dining room and they were providing assistance for two people to eat their meals. They also got up on occasions to go and help other people with their meals. We observed this member of staff rushing one person and putting a spoonful of food in a person's mouth before they had finished their previous one. This placed the person at risk of choking.

We observed one person, who had been identified as being at risk of not eating enough, was reluctant to eat. They had difficulty holding their cutlery but there was no adaptive cutlery available. Their care plan, which had last been reviewed in March 2016, stated that they could eat independently but this was not our observation. Three different staff tried to help the person during a 90 minute period and reheated the meal when it became cold.

Recording of food and fluids was not good throughout the service. We found that some records were comprehensively filled in but others were completely blank. Some records conflicted with each other which meant staff did not have an accurate picture. The records for one person at risk of not eating or drinking

enough, showed that they had received a total of 850 mls of fluid in five days and only minimal foods. There was no record to indicate that alternative foods had been offered and no clear instructions for staff, although the person's care plan clearly stated that they should be encouraged to eat. We did not observe staff encouraging this person to eat on either of our inspection visits and were not assured that the person was being supported to have adequate food and drink.

People's weights were mostly well monitored but we did note one person, who had sustained weight loss of 3.1kg over a three month period was only being weighed monthly. According to the Malnutrition Universal Screening Tool (MUST) which the service was using, such an unplanned weight loss should lead to a person being weighed weekly to monitor their condition.

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

We observed that some staff demonstrated skills and expertise in supporting and caring for people and were knowledgeable about people's care needs and health conditions. However, others did not demonstrate that they were able to effectively prioritise people's needs and lacked basic skills.

When first employed staff undertook an induction which was designed to ensure they had the required skills and competences to carry out their role. We reviewed three staff files, including one for a member of staff on long term placement from an agency. Each had received a structured induction, checks on their competency and supervision sessions. Agency staff had an induction checklist which staff went through before they could work unsupervised. However, in practice, we saw that this did not work as an agency staff member was left alone for nearly an hour on their first visit to the service before going through the induction checklist. At one point they told us they did not know where the senior staff member working with them had gone.

Although supervision was provided regularly for people we found it did not always centre on staff members' individual needs and we saw the same agenda for several members of staff. This was a concern as all three had at least one warning on record following disciplinary investigations for different incidents and these had not been explored in supervision sessions. The length of supervision sessions, where recorded, was very brief. For example, one staff member, who had received two written warnings in September 2016 had only received one 15 minute supervision session since.

Staff, who had been employed on long term contracts through an agency, had been employed with minimal information known about them and their suitability for the job was only assessed after they were in post. We observed some of these staff carrying out their roles and saw that they did not all have the required skills and experience. One person employed in this way had such a poor level of spoken English they were not able to tell us how long they had been working at the service or tell us the numbers required to use the electronic keypads. Records from this person's agency showed that this person had undertaken training in a variety of subjects including mental health, dementia and health and safety. This, and our observations of this person's practice, led us to question the efficacy of this training.

Staff received relevant training including training in nutrition, diabetes and end of life care which had been provided for staff when we last inspected the service. We noted, however, that training in pressure care and mental health was not provided even though staff were expected to provide support in these areas. Staff were positive about their training and were keen to learn. A trainer providing MCA and end of life training commented on how enthusiastic the staff were, although they were also struck by the lack of basic knowledge staff demonstrated at the start of the session.

At our last inspection we found that the service had failed to ensure that people's capacity to consent to care and treatment had been properly assessed and action taken in their best interests where people lacked capacity to make decisions. At this inspection we found things had improved but some areas of concern remained. Care plans contained assessments of people's capacity to make day to day decisions and we observed staff establishing people's consent before offering care and support.

We noted that people's capacity to consent to taking medicines, including medicines administered covertly, and to receiving personal care had been assessed. People's capacity to consent to having a lap belt on a wheelchair and bedrails in place had also been assessed. Where people did not have the capacity to consent the correct process was mostly in place. However we did also find that one person had been given an influenza vaccination without any accompanying MCA process.

Do Not Attempt Resuscitation (DNAR) orders were in place for some people and had been filled out correctly. Staff had been issued with a list of people who had a DNAR and one senior member of staff confirmed to us that they carried the list with them when on shift.

Given the lack of skills, expertise and basic English language competency for some staff we were not assured that all staff were aware of who had a DoLS in place. We observed one person trying to get up from their chair and being told, "Stay where you are please" by a member of staff. We also noted that one person's care plan had a section called 'Infringement of rights' which stated 'all residents' bedrooms are kept locked during the day for health and safety reasons'. Staff were not able to explain why this restriction on people was necessary or if it was lawful.

The manager told us at our last inspection that 'a few' DoLS had been authorised by the local authority and others had been applied for. We have still not been notified to confirm anyone had a DoLS in place, although this is a requirement.

Records showed that people had access to a variety of healthcare services including GPs, district nurses, falls team, psychiatrists, opticians, occupational therapists, dieticians and chiropodists. People told us staff responded quickly to their healthcare needs. One relative told us, "[My relative] collapsed a few times over the last few months and was taken to hospital for tests…They called me each time to inform me". We noted that when a concern was identified with a person's health the service took prompt action to refer the concerns to the GP or other healthcare professional. We saw good practice related to catheter care for one person and guidance from the district nurse was being followed by staff.

Although referral to healthcare support was generally good we also found evidence that staff were not always aware of people's current health needs. For example we observed that a senior staff member asked a colleague when a person who used the service had last had their dressings changed by the district nurse. The other senior staff member was not able to tell them and there was no information on the handover sheet about this. Another person had sustained a fall. 15 minute observations had been put in place but had not been carried out in practice. One observation check had also been filled out in advance which meant that we could not be assured that records documented the person's current condition accurately.

Requires Improvement

Is the service caring?

Our findings

People who use the service, and their relatives, were mostly happy with the way staff provided care and support. One person said, "They always seem nice. They look after me well". Another person commented, "The staff are very nice, very kind" and others echoed this. We saw numerous examples of staff demonstrating patience and kindness whilst supporting people and were particularly impressed with an agency staff member who was very kind to a person in distress.

One member of staff was observed to spend a long time encouraging a person to eat, getting down to their level and speaking softly in a kind manner. We noted that one person's care plan gave specific instructions for staff to say to them when they became confused and distressed. Staff were observed spending time reassuring people when they became confused but these interactions were often quite brief as staff were so very busy.

We also observed less caring practice and people being ignored. One person was observed to become distressed and asked "Can somebody help me please? I don't know where I am". Four members of staff were present and nobody went to help them or comfort them.

We again observed that some people's level of English language skills had a negative impact on people who used the service. We saw staff leaning over people and raising their voices in an attempt to be understood. One person's care plan stated that they were 'able to communicate well and enjoys chatting'. We observed this person repeatedly making loud noises and other people who used the service shouting at them to be quiet. Staff did little to intervene or engage the person and the noise made others distressed. One person said, "I'm going. I need to get out the way. I can't stand this noise". We noted other occasions when people appeared distressed and crying and staff told us, "[They] always do this. It's normal". Action was not always taken to distract people and attempt to minimise their distress.

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

The service had improved the way people were involved in making decisions about their care and relatives were positive about the way they had been involved. One told us, "I have been consulted on my [relative's] care plan" and we observed another relative being given a care plan to read through and comment on. There was less engagement with people living with dementia to establish the views on their care, as far as they were able to express them. Although care plans were good in the way they outlined people's needs following consultation, we did not always see the staff working in accordance with the outcomes of these consultations.

We did not see a strong commitment by the service to provide information in formats which would be accessible to people. There were clear signs identifying the toilets and bathrooms but we saw that menus did not include pictures or photographs. People living with dementia were not routinely reminded of the food choice they had made earlier so some people may have been confused about what they were about to eat. We identified all these issues at our last inspection and saw little in the way of progress.

People's dignity was not always maintained. At our last inspection we found the provision of bright coloured plastic plates and beakers for everyone, regardless of need, to be undignified. The provider's action plan following this inspection stated that they would source more suitable crockery and cutlery but this had not taken place.

Also at our previous inspection we noted that a hoist was stored in one person's bedroom, even though they did not use the hoist themselves. Staff confirmed that this was the usual place for this equipment to be stored. The service's action plan stated that they would now store hoists in bathrooms.

At this inspection we asked to view the hoist to ensure it was in good working order. We found that it was stored in a different person's bedroom overnight. When we asked to see it a staff member entered the person's room where they were asleep, put the light on and removed the hoist. The person woke from sleep. We asked if this hoist was for this person's sole use and staff told us that nobody else would need the hoist during the night. This was not the case and we saw the person disturbed in the same manner two more times. Staff told us, "It's true we wake [them] up but it can't go anywhere else". This demonstrated a fundamental lack of consideration for this person's comfort, privacy and dignity. We insisted that the hoist be stored elsewhere and staff moved it to a shower room immediately.

Although we had highlighted concerns about written language at our last inspection we found that bowel chart records still contained categories titled 'overflow' and 'mucky'. This is not professional or respectful language. Some staff's spoken English, although improved overall, occasionally failed to demonstrate respect and treated people as if they were children rather than taking account of their advanced dementia. For example we asked if one person, who was not settled and calm, was ever given something to occupy their hands as they were very tactile and were grabbing onto fabric and clothing to rub between their fingers. This issue was also raised at our last inspection. A staff member said, "[They're] constantly throwing it out. [They] will throw in a minute if we get one". We then observed the staff member fetch a toy dog which the person stroked and cuddled for the next two and a half hours. We were not at all assured that this action would have been carried out by the staff member had we not raised a concern.

Similarly we noted a person whose nightdress was too short. It was clear, when they sat down, that they were unhappy about their attire as they kept trying to pull the nightdress down to cover their knees but staff did not appear to be aware and took no action to maintain the person's dignity.

As mentioned earlier in this report we observed an incident where a person was left waiting for one hour and ten minutes to be taken to get changed having been incontinent. As well as being a staffing issue we also saw that the senior staff member concerned had very little thought for this person's dignity and comfort. Instead of going as a priority to try and arrange an additional member of staff to cover for a few minutes they went off to carry out other chores such as making drinks and late night snacks for people. There was no understanding of the possible distress this situation may have caused the person concerned.

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

Requires Improvement

Is the service responsive?

Our findings

We saw that people's care and support needs were assessed before they moved into the service and a care plan drawn up once they moved in. People who used the service, or their relatives, had mostly been involved in developing their care plans and plans reflected how people wished to receive their care and support. We found that plans included detailed guidance about how to support and care for people and they were mostly regularly reviewed by the manager, however they did not all reflect people's most current needs.

Systems did not ensure that people's individual needs were met. For example, as previously documented in this report, a staff member was unaware that a person had fallen earlier in the day and required monitoring closely. Agency staff were left to support people whose needs they did not know. We sat in on the handovers from the day to the night shift and found them to be brief and very basic. Staff made comments such as, "He's fine" and '"She was ok". We were not assured that the staff beginning their shift had an accurate picture of people's needs at that time.

Throughout our inspection we saw few examples of care being focussed on individual needs. People's basic needs were met in that they were reasonably well groomed, were taken to the toilet, had food and drink and a warm room to sit in. However care was very much task centred and people were processed through the day until it ended and they were taken back to their beds. There was little in place to ensure people had a good quality of life, where they were fully involved in the life of the home, appropriately occupied and had a sense of purpose.

People were observed throughout the day with very little to do and were waiting for the next meal or drink. One person commented, "I just sit here. There's nothing much to do really" and this was our impression. The service had a planned programme of activities and events two days a week which was actually fewer days than at the time of our last inspection. We found that the activities co-ordinator was off sick and no replacement had been found to cover their hours and so people were left with very little to occupy them.

We observed staff attempt to provide activities but these were often quickly abandoned as staff were needed elsewhere. One game of hoopla was set up and presented a trip hazard when nobody wanted to play and it was not immediately cleared away. We saw a reminiscence game which people enjoyed and staff sitting with a couple of people doing drawing and looking at magazines. Some staff found time to chat with people for a short while, especially on the evening shift. At other times staff did not engage with people and stood around waiting for their next task rather than chatting to people. This may have been in part due to the limited English language skills of some staff. One person who used the service told us they were lonely and had little to do.

In the main house the television, which only two or three of the 24 people could easily view, was on all the time, sometimes with the sound turned down or with the radio also on. People were not asked about this and little thought was given to what programmes people might enjoy. The noise from the television or radio alongside the noise from some of the people who used the service was considerable at times. This environment was not appropriate for people living with dementia and had been raised as an issue at our last

inspection.

Meetings were held for the people who used the service. We viewed the most recent meeting minutes and saw people had an opportunity to raise issues which concerned them about their care. It was not always clear what actions had followed. For example one meeting recorded that a person 'gets lonely in their room' but there was nothing recorded about what was done in response to this concern. The provider told us that they had just begun to take issues forward from resident meetings and review them in the staff meeting.

The service had a complaints procedure and people, and their relatives, were aware of it. The service had not received any formal complaints since our last inspection.

Inadequate

Is the service well-led?

Our findings

At our last inspection we had significant concerns about the leadership at the service. The provider had not been able to demonstrate to us that they had oversight of all the issues at the service and were capable of moving the service forward and focussing on ways to constantly improve. There had been no service improvement plan and no links to local networks where expertise and ideas could be shared. We met with the provider to discuss the serious nature of our concerns and they supplied us with an action plan outlining how they intended to bring about the required improvements. We found at this inspection that, although some improvements were in evidence, the provider had not made the significant improvements they needed to.

We did not find a lack of willingness to make changes on the part of the provider. The manager told us they had very recently signed up to the Prosper Project which is an Essex County Council initiative to reduce hospital admissions as a result of falls and preventable infections, although this was yet to be embedded in staff practice. They had also engaged a consultant to advise them about their quality assurance systems.

However we found there was a lack of competence in some areas and the provider did not carry out any in depth analysis. For example we noted that three recently appointed members of staff had left the service in the last two weeks. One was a senior and another had been recruited as a deputy manager. The deputy manager only stayed a matter of days. We asked the provider why these staff had left in this manner but they did not know and suggested that the work might be too hard. It is unusual for a significant number of senior staff to leave in this way but the provider had made no effort to try and find out why. No exit interviews, or even informal chats, had been carried out and the situation had been accepted.

Supervisions and disciplinary procedures had been used to address poor staff performance but we did not see enough evidence to demonstrate that this drove improvement. We saw one file where the person had two final written warnings in place. These had been given in the same month. One was for 'not treating a resident properly'. The person also had a note from the previous month's supervision stating they had 'to improve behaviour with residents and improve the tone of voice'. We saw no evidence to suggest that the person had received any additional support or training and we found that their poor performance was simply being recorded rather than improved.

We questioned the provider's judgement in employing people with limited or no care experience and limited English and then failing to adequately support and supervise them. This situation had not changed significantly since our last inspection. Such staff continued to work without close supervision and support, caring for people with complex and demanding needs.

At this inspection we found some improvements with regard to the attempt to monitor the quality of the service. We saw, for example, that the manager had carried out four unannounced spot checks on the service, one of which was at night. Checks were carried out in September, October and two in November. The report of each of these documented both good practice and also some significant shortfalls in the safe and effective delivery of the service. The results had been shared with the staff at a staff meeting. This

exercise highlighted once again that, although the provider had a clear idea about how to deliver the service in a safe, caring and effective way, the staff were not always following the most basic principles of good care and progress was not evident. The night visit found the kitchen door left open and had concerns related to people's dignity; we also found this at our evening inspection. One spot check commented on the fact that some key staff had been later for handover or had not attended it. We also found this was still an issue during our inspection.

We did see improvements with regard to the provision of training for staff but many of the other areas outlined in the service's action plan following the last inspection had not been completed. Given the serious concerns we identified at the previous inspection this lack of progress was concerning. The manager was not proactive in the monitoring of the quality and safety of the service. For example we asked to see the audits of the call bells. We found that this was not undertaken, unless a person had had a fall. This meant that the provider did not have a clear picture of how long staff were taking to respond to people's needs on a day to day basis over a 24 hour period. We found it was possible to export the data from a specific day and analyse it to see if there were any issues but the provider had told us they were not able to do this.

Medication audits were carried out and the provider had a general audit in place which covered a variety of areas. The provider told us they used this to analyse trends within the service but we did not see a clear positive impact of these audits

We noted that the September audit had identified that some records, for example the care needs summary and the care plan contained conflicting information. We found this was still the case for some of the records we sampled at our inspection. Other records, although improved from our last inspection, were not of all of a good standard. We found that staff had a lot of recording to do and we observed staff rushing to write records at the end of their shift. We observed staff writing records when they had not actually been supporting the people whose records they were filling in. This is not good practice and did not assure us that the records were accurate.

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