Care UK Community Partnerships Ltd

Cavell Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 5 and 6 July 2016. The first day was unannounced.

Cavell Court is a service that provides accommodation, residential and nursing care for up to 80 people some of whom are living with dementia. At the time of the inspection, care was being provided over three floors. The top floor provided nursing care to people, the middle floor care to people living with dementia and the ground floor to people with nursing and residential needs, some of whom were living with dementia. There were a total of 44 people living over these three floors when the inspection took place.

There was no registered manager working at the service. The last registered manager left the service in April 2016. A new manager has been recruited but had not commenced working at the service at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the home is run. The home was being managed by the provider's operations support manager with support of other representatives from the provider.

At this inspection we found four 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 this report.

The provider had ensured that the number of staff they had calculated as being required to work in the home had been regularly met. However, these staff had not always been deployed effectively to enable them to meet people's individual needs in a timely way. People did not always receive care based on their individual needs and preferences. The high use of agency staff meant that people did not always receive care from staff who knew them well. Some people had not received their medicines safely.

The principles of the Mental Capacity Act were not always being followed when making decisions for people who lacked the capacity to consent to their care. Therefore, people's rights may not have been protected.

Some staff lacked sufficient training to provide them with the skills and knowledge to provide people with safe and effective care. Most staff were kind, caring and compassionate but this was not consistently applied. Some poor care practice was demonstrated which meant people were not always treated with respect.

People were involved in making decisions about their care and they received enough food and drink to meet their needs. The staff supported people with their healthcare needs and the premises where people lived and the equipment they used were safe.

People's complaints had been fully investigated. However, not everyone knew how to make a complaint or

who to speak to if they had a concern.

The provider had recognised that a number of improvements were required to how the home was being run. Systems had been put in place to achieve this. However, these were currently not all effective at assessing and monitoring the quality of care provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks to people's safety had been assessed but actions were not always taken to reduce the risk of them experiencing harm.

Staff had not always been deployed effectively to meet people's needs.

People's medicines were not managed safely.

Any incidents of alleged abuse had been reported to the provider and appropriate organisations but staff knowledge in relation to safeguarding people from the risk of abuse required improving.

The premises were safe and the equipment people used had been regularly serviced to make sure it was safe to use.

Is the service effective?

Requires Improvement

The serviced was not consistently effective.

Not all staff had received the training they required to provide people with effective care.

The principles of the Mental Capacity Act had not always been followed when making decisions on behalf of people about their care.

People received a choice of food and drink and sufficient amounts to meet their needs.

People were supported to maintain their health.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some staff were kind and caring but others did not show people consideration and some people's dignity was compromised.

People were given choice and supported to make decisions

about their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care needs had been assessed but not all of their preferences on how they wanted to be cared for had been explored.

Staff did not always engage people in activities that were meaningful to them.

Complaints received had been fully investigated but improvements are required so people understand how to complain if they wish to do so.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Not all the current systems in place to monitor the quality and safety of the care provided were effective.

There was no registered manager working at the home and therefore, leadership within the home was not consistent.

Cavell Court

Detailed findings

Background to this inspection

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

This inspection took place on 5 and 6 July 2016. On the first day the inspection team consisted of two inspectors, a specialist advisor who specialised in pressure care and nutrition 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. On the second day the inspection team was one inspector and a medicines inspector.

Before the inspection, we requested that the provider complete 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. This was received from the provider. We also reviewed other information that we held about the service. Providers are required to notify the Care Quality Commission about events and incidents that occur including injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us. We had requested feedback before the inspection from the local authority quality assurance team and clinical commissioning group.

During the inspection, we spoke with six people who used the service and six relatives of people who received care at Cavell Court. We also spoke with one nurse, six care staff, the lifestyle coach who coordinated activities and the deputy manager. We also spoke to representatives of the provider including the operations support manager and the regional clinical lead nurse. Along with general observation, we used the Short Observational Framework for Inspection (SOFI) to assist us with this. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

The records we looked at included six people's care records and other information relating to their care and four staff recruitment records. We also looked at records relating to how the quality of the service was monitored.

After the visit we requested further information from the operations support manager. This included information in respect of the assessment of risk, staff training information and how the provider assessed the quality of the care provided. All of this information was received but some of it was not sent within the timeframe stipulated.

Requires Improvement

Is the service safe?

Our findings

During the inspection, we saw some poor care practice which placed people at risk of harm and some risks to people's safety had not been assessed.

One staff member was seen to give a person their lunch. The person was lying back in a chair. Although the person had not been assessed as being at risk of choking, giving someone food when they are lying back increases this risk. We therefore had to ask the staff member to sit the person up so they could receive their food and drink safely.

It had been noted in one person's care record that they had in the past, picked up a hot kettle and walked around a communal area with it which had been noted as a concern. They lacked the capacity to understand the risks of taking such action. We saw this person walking around a communal area near the kitchen where the kettle was kept. The kettle had just been boiled and was full of hot boiling water. There were no staff in attendance. This risk had not been assessed by the provider. It therefore posed a risk to this person and the other people living within this area of the home. We brought this to the operation support manager's attention who confirmed to us after our visit, that they had assessed the risk and had taken actions to reduce this risk of people experiencing harm from boiling water.

We saw the same person trying to move the dining room furniture around. A staff member tried to stop the person by pulling them away from the table. This caused the person to become angry and distressed. Later in the day, we saw another staff member try to restrain the person from sitting in a chair they wanted to sit in. Again, this made the person angry which posed a risk to the person, other people living in the home and the staff. The person's care record stated that when they become distressed or upset that they should be distracted by the staff with an activity. However, this did not happen.

On another occasion, we saw a staff member assisting one person in their wheelchair. The staff member left the person temporarily to help someone else. They did not put the brakes on the wheelchair and the person tried to stand up. As they did this, the wheelchair moved backwards. The staff member saw this happen and quickly came over to the person to help them sit back down in the wheelchair. Although the person came to no harm, the risk of them falling had not been managed well.

Our medicines inspector looked at how information in medication administration records and care notes for people living in the service supported the safe handling of their medicines.

People we spoke with said they usually received their medicines on time without delays. One person told us, "They [staff] come round and give us them (medicine) when they're due morning and night." Another person said, "They're [the staff] are always asking me about that (pain relief), do I have a headache? I'm sure if I asked they would give me some."

However, we received feedback from one person that on occasions they had received either the incorrect medicine or an incorrect amount of their medicine. They told us, "Somebody gave me the wrong pill, I think

it was because they started taking me every week to the surgery because they hadn't got it right." A relative said, "There have been issues with medication, if I hadn't been here they [family member] would have had the wrong medication, I had to go to get somebody else." Another relative told us, "I have seen [staff member] dish out my [family member's] medication, she gave them the wrong amount of medication. On another occasion the medical lead was dispensing medication, four times it was incorrect. Their understanding was wrong, not the medicine administration sheet."

Records showed that people had not always received their oral medicines as prescribed. We noted there were numerical discrepancies for some medicines where we could not account for them. For one person we noted that an incorrect dose of their anticoagulant medicine warfarin had been given to them on several occasions in the recent six-week period which was unsafe. We also noted that for medicines prescribed for external application such as topical creams, there were gaps in the records of their administration so the records did not confirm these medicines had been applied as prescribed. One of these people had developed a pressure ulcer on their heel. A cream had been prescribed to be applied to their heel each day but the records indicated that this had not been done. When asked, a senior member of staff told us the person sometimes refused the cream but this had not been reflected in the records.

Not all medicines were being stored safely for the protection of people who lived in the home. We identified a container of specialist medicines that required extra checks and special storage arrangements, in a medicine trolley. This needed to be stored in a cabinet that met certain regulations.

When people were prescribed medicines on a when required basis, there was written information available to show staff how and when to administer these medicines. However, more detail was required for medicines prescribed to support people when they became upset or distressed. This was to ensure they were used appropriately and consistently. In addition, when these medicines were given to people there were no records showing reasons that justified their use.

Charts were in place to record the application and removal of prescribed skin patches, however, we noted gaps in the records. For people managing their own medicines, there were records for when staff undertook checks to support people to do so safely. However, these had not always been fully completed.

Staff authorised to handle and give people their medicines had received training and had been assessed as competent to undertake medicine-related tasks. However, we found some issues as described above when staff had given people their medicines incorrectly.

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

We noted some supporting information to enable staff handling and giving people their medicines to do so safely and consistently. There was personal identification and information about known allergies and medicine sensitivities. Written information on people's preferences about having their medicines given to them was also in place. We observed part of a morning medicine round and saw staff following safe procedures when giving people their medicines.

Prior to the inspection, we had received a concern that risks associated with people developing a pressure ulcer had not been managed well.

We looked at the care and treatment that four people had received when they had developed a pressure ulcer. The risks associated with this had been assessed and regularly reviewed. Specialist equipment had been put in place and staff were ensuring that people were re-positioned regularly to reduce this risk. The

staff we spoke with were knowledgeable about pressure care and most of the nursing staff had recently received training on the subject. However, we did see that one person's pressure ulcer whilst being treated, had not been re-assessed to make sure the dressing being applied was the most appropriate. This meant that the pressure ulcer may not have healed as effectively as it could have done.

Other risks to people's safety had been assessed. This included risks in relation to falls, eating and drinking, choking, the use of bed rails and when supporting a person to move. Clear information on what action staff needed to take to reduce these risks had been recorded within people's electronic care records. We found that some of these risks were managed well and that these risks were reviewed each month. This was to make sure that the actions being taken to reduce the risk were still relevant. People who were at high risk of falls had beds low to the floor and crash mats by their bed so if they fell out, their risk of injury would be reduced. Equipment that they needed to help them walk safely was always placed near them. Where people had bed rails on their bed, an assessment had been conducted to make sure that they were safe to be in place.

Prior to the inspection, we had received some concerns that there were not always enough staff working in the home to meet people's needs and to keep them safe.

We received mixed feedback from people regarding whether there were enough staff to meet their needs and to keep them safe. One person told us the staff responded quickly when they requested them. They said, "Sometimes they come very quickly, it's always fairly quick." A relative said, "They're fairly quick on the buzzer, they do answer within a minute or two." A further relative told us, "Yes the staff are excellent, there is always someone around to speak with and help [family member] when they need it."

However, one person said, "I think they're short at weekends, it can be a long wait." Another person said, "I think there are too many agency staff, they can't get the staff day and night." A relative told us, "There are times when it would appear that there is an inadequate number of staff by ratio to the number of residents on the floor." Another relative said that on occasions their family member had had to wait for support from the staff and that they had noticed less senior staff at the weekends. They told us, "This morning [family member] woke up unexpectedly and I used the call bell and they responded quickly. Generally speaking staff will try and respond as best they can, but there are limitations because there are other people that are very poorly here." Another relative said, "Their [family member]'s pressure mat will trigger a call but the response time [by staff] is too slow and makes them vulnerable."

The staff we spoke with gave us mixed views about the current staffing levels. Three staff told us they felt the staffing levels were sufficient and that these had improved recently. However, three other staff said that sometimes they had difficulty meeting people's care needs in a timely manner. This included being able to assist people to get up when they wanted to or provide them with personal care.

We did not observe any concerns in relation to staffing levels during the inspection. Staff were seen to respond to people's request for support in a timely way. However, on the first day of the inspection, we became aware that an extra member of agency staff had been asked to work on the middle floor of the home. The operations support manager told us this was because they were conscious that staff would be taken off the floor to speak with the inspection team and they wanted to make sure people received the care they needed. This meant that it was difficult to ascertain from our observations whether there were usually sufficient staff working on this particular floor.

The operations support manager told us that the number of staff working within the home was based on people's individual needs. They said that this was reviewed regularly. Due to people's feedback in relation to

staffing levels, we checked staff rotas for the four weeks prior to the inspection. This was to see whether the number of staff required to work within the home as deemed necessary by the provider had been consistently met.

We found that the home had on a regular basis, met the required number of staff as deemed appropriate by the provider. We spoke to the operations support manager about the feedback we had received about staffing levels from some people living in the home, visiting relatives and the staff. They told us that historically there had been an issue with how the staff had been deployed within the home. This had meant that people had not always received assistance in a timely manner when they needed it. They said that plans were in place to deploy staff more effectively in the near future to prevent this from happening. Therefore, improvements are required to make sure that people receive assistance from staff when they need it.

We saw that a high number of agency staff were being used to provide care to people on some days. The operations support manager told us the plan was to reduce the number of agency staff used as permanent staff were recruited. We saw that less agency staff had worked in the home during the week of our inspection compared to previous weeks.

The people we spoke with told us they felt safe living at Cavell Court. One person told us, "I do feel safe, it's the way I'm treated by the carers, they are wonderful." Another person said, "Yes I am safe here." A relative told us, "The staff keep [family member] safe."

We saw that any concerns that had been raised with the management team in the home about possible alleged abuse had been reported to the relevant authorities for investigation. Most of the staff we spoke with knew how to protect people from the risk of abuse. They understood the different types of abuse that could occur and were clear that they needed to report any concerns they had to their manager. However, most staff were not aware of whom to contact outside of the home if they felt they needed to escalate their concerns. When we checked staff training records, we found that some staff had not completed training within this area. This included staff who had been working in the home for over a month. Improvements were therefore required to make sure that staff had sufficient knowledge to enable them to identify and report safeguarding concerns effectively.

Any incidents or accidents that occurred were recorded and analysed. Trends were identified and action taken to reduce the risk of the person experiencing a similar accident again. For example, one person had fallen a few times. In response to this, the person had been seen by a specialist falls team who had given advice on how to reduce this risk and these suggestions had been implemented.

Risks in relation to the premises had been assessed and regularly reviewed. We saw that the emergency exits were well sign posted and kept clear and that fire doors were kept closed. The equipment that people used, such as hoists, had been regularly serviced to make sure they were safe to use.

The staff files we viewed showed that the relevant checks had taken place before the staff member commenced their employment. This was to make sure they were safe to work with the people who lived within the home.

Requires Improvement

Is the service effective?

Our findings

Prior to the inspection, we had received some concerns that staff had not received enough training to provide people with effective care.

People told us that they felt the permanent staff who worked in the home were well trained. One person told us, "Most of the staff up here are very well trained and all seem to sing from the same hymn sheet." Another person said, "Oh yes, I think they have, some are very experienced and have been doing the job for a long time."

However, people said that they noticed a difference between the permanent staff and agency staff. One person said, "The normal staff are good to me, there's such a gap between them and the agency." Another person told us, "The agency staff are not very good, I am always having to show them what to do."

Three relatives told us they felt that not all of the staff were not well-trained. One relative said, "I feel the level of training received is mixed but all of the staff are happy and jolly." Another relative told us, "[Family member] has had a permanent catheter infection since they've been here. I have been teaching the staff how to look after it as they do not know." Another relative said, "I'm not sure if the management are arranging enough staff with the trained skills."

All of the staff we spoke with told us they felt they had received enough training to enable them to provide people with effective care. They said that this had included practical training in areas such as moving and handling and e-learning on the computer. However, some of them did comment that they felt new staff required more training in certain subjects. Some staff had received training in pressure care management and wound care. A training session on diabetes was happening on the day of the inspection.

During the inspection, we saw some staff using poor care practice. This included when assisting one person to move and another to eat and drink. We observed that staff did not support a person appropriately when they became upset and distressed. We checked two of these staff member's training records. We found that the staff member who had demonstrated poor moving and handling practice had not received formal training in this subject. The staff member who did not support the person well when they became upset and distressed had not received any training in this area. We therefore checked what training and supervision staff within the home had received.

We found that a number of staff working within the home had training that was either outstanding or overdue. Therefore, we were not assured that they all had the relevant up to date knowledge and skills to provide people with effective care.

We saw from the training matrix that detailed the completion of staff training, that two of the seven nurses employed had training overdue in fire safety and moving and handling. These had been overdue since April 2016. Most staff had not received training in basic life support or first aid at work.

Six of the thirty staff/nursing staff who had been working for the home for more than three months had not received basic training in dementia awareness. Thirteen were overdue for classroom based fire training two of which had been overdue since December 2015. Seven had overdue health and safety training.

Twenty-four of the 54 care/nursing staff working in the home had worked for the provider for less than three months at the time of the inspection. The operations support manager told us that new staff to the home, who were completing their induction training over a 12 week period, should have completed training in safeguarding adults, moving and handling and fire during their first week. However, we saw that this had not been the case. Fire training was overdue for 14 staff, 11 had not completed moving and handling training and 14 had not completed safeguarding of adults training. We also saw one new member, who had worked at the home for two days, being asked to provide people with care unsupervised. We were told by a senior member of staff that they should have been shadowing staff only.

We spoke to the operations support manager about staff supervision. Supervision is needed so staff can discuss their performance, development and training needs. The operations support manager told us that in the past, the staff had not received the required supervision but that this had improved since June 2016. We saw that around half of the staff had received some form of formal supervision in June 2016. However, no staff who were due to receive one, had received an annual appraisal.

We asked the operations support manager what supervision new staff received during their induction period in relation to their care practice and progression. The operations support manager advised that each staff member had a meeting after their 12 week induction period. This was to establish whether the staff member was competent to remain working for the provider. They said that during their induction period the staff member completed a booklet to show what training they had completed. This was also signed off by a team leader periodically when they were happy that the staff member was competent within certain areas. We asked to see a copy of this booklet but were advised that they were not available. This was because the staff kept them at their personal residence and not within the home. Therefore, we were unable to check whether new staff had received any formal supervision or checks on their practice during their induction period.

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

The operations support manager acknowledged that some staff training was overdue and told us that plans were in place to address this and to improve the training that the staff received. They said that the provider had recently implemented a new dementia strategy which was being rolled out across the provider's homes. The operations support manager had plans to run some dementia workshops for the staff to improve their knowledge. They advised us after the inspection visit that training staff required had been booked to take place in July 2016. They also told us they had recognised the issues with staff supervision and appraisal. They confirmed that plans were in place to start appraisals once formal supervision was in place.

We asked the operations support manager about agency staff and how they made sure they had received relevant training. They told us a profile of each agency staff member was sent to them prior to them starting work so they could check they had relevant experience. We viewed one of these profiles and saw this to be the case. The operations support manager told us that the agency staff member would then have a day's induction training in the home.

We received mixed views regarding whether people's consent was sought before the staff performed a task. One person told us, "Oh yes they always ask me." A relative said, "Whenever I've been in there with them they always say '[family member] is it all right if we do this?', I have never seen staff go in and not check that [family member] needs anything". However, one person told us, "They [staff] don't ask, they just get on with

it (personal care)."

There were some people living in the home who lacked capacity to make decisions about their own care. Therefore, the staff have to work within the principles of the Mental Capacity Act (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

Most of the staff we spoke with had an understanding of the MCA and DoLS and how this legislation impacted on their care practice. They understood that any decisions they made on behalf of the person had to be in their best interests if they were unable to make the decision themselves.

We observed staff applying the principles of the MCA when supporting people to make day to day decisions about their care. For example, helping people make a decision about what food they wanted to eat by showing it to them or showing them different chairs they could choose to sit in.

Each floor of the home was split into different units. Each of these units was accessed by a key code. The codes were secreted within a visual display of flowers within a picture frame on display adjacent to the key pad. This facility was in place to enable people who could understand the code to access the different units freely.

For specific decisions about people's care, we saw some evidence that the principles of the MCA had been followed when the staff at the home were making decisions in the best interests of people. However, this had not always been consistently applied. For example, two people had a sensor mat by their bed to alert staff to their movements. An assessment of these people's capacity had not been completed. There was nothing to show what support these people had received to make these decisions, whether any less restrictive actions had been considered or who had been involved in making this decision in the person's best interests. Another person had bed rails on their bed but there was no best interest decision regarding their installation and use.

The regional clinical lead nurse told us they had recognised this and were currently working on assessing people's capacity to make their own decisions. This was to make sure that the actions taken were appropriate and correct. Therefore improvements were required to make sure that the MCA principles were fully followed to protect people's rights.

The provider had assessed the people who lived at Cavell Court to see if they were depriving them of their liberty in their best interests. Where they felt they were, they had made an application to the local authority for permission to do so to ensure that the deprivation was lawful. They had received authorisation to deprive two people of their liberty in their best interests and were waiting to hear about the others. In the interim, the provider made sure that any restrictions in place were regularly reviewed to ensure they were the least restrictive possible.

Most people told us that the quality of food was good and acceptable to their needs. One person told us, "The food is pretty good." Another person said, "The food is lovely. It's the way they serve you, it used to be a long-winded job, they just got better at it."

People told us they had a choice of food and that alternatives would be made for them if there was nothing on the menu they liked. One person said, "We have a choice. We're going to be getting a menu with all the meals on, they asked me at lunchtime what I want, and if I don't like the choice available I could have scrambled egg on toast or something else." Another person told us, "I don't starve, you can have biscuits during the day and if I don't like the evening meal I can have something else if I want to."

The relatives we spoke with were also happy with the quality of the food served. One relative stated they found the food to be fresh and that it varied in quality.

We observed that people were given a choice of food and drink at lunchtime. Three courses were available. Most people who required assistance to eat received this although we saw that one person was not prompted very often which resulted in them not eating much of their meal. At one point, the relative of another person helped them to eat some of their food. The person's care record stated they required prompting to eat their food and that they had been assessed as being at risk of losing weight. We spoke to the operations support manager about this who agreed to look into the matter. Records showed that this person had been monitored regularly to make sure they were not losing weight. The staff told us that they had given the person a number of snacks to eat after their lunch which they had consumed.

The relatives we spoke with were happy that their family members were assisted to eat sufficient food to meet their needs. One relative said, "Initially [family member] needed their food to be fork mashable but we agreed to include some chicken breast. Up to now we have gone on to pureed food, they re-form and arrange it in a nice way or in little ramekin dishes. Yes, it's fine, I've tried it myself, I make sure it's the right temperature." Another relative said, "They [the staff] were good at providing finger food when [family member] refused to eat, very nicely presented, encouraging them to graze."

People said they had access to plenty of drink. The relatives we spoke with agreed with this. One person told us, "I've always got a jug of water and it's replaced daily, I walk out and ask for a hot drink, they bring it to me because I would spill it." A relative told us, "They [staff] are good at maintaining their food and fluid intakes." We saw staff offering people hot and cold drinks throughout the inspection.

Where people had been assessed as being at risk of not eating or drinking, we saw that people's food and fluid intake had been monitored. This was to make sure it was sufficient to meet their individual needs. Specialist advice had been sought from GPs, dieticians or district nurses when concerns had come to light. People who were underweight had their meals fortified with extra calories and received milky drinks between their meals. Snacks were also available which included cakes, biscuits and scones. We were therefore satisfied that people received sufficient food and drink to meet their needs.

People told us they received support to maintain their health. One person said, "I get to see my own doctor when I need one, they'll call him for me if I need one." The relatives we spoke with agreed with this. One relative told us, "They [staff'] do call a GP, the [GP] practice is very responsive." Another relative said, "When [family member] has an issue that is escalated in some way they [staff] contact the appropriate professional at the right time."

We saw that a GP visited people regularly and worked with the staff to implement any changes that were required to support people's healthcare. People also had access to other healthcare professionals such as mental health professionals, occupational therapists, physiotherapists and chiropodists. We were therefore satisfied that the staff supported people with their healthcare needs when this was required.

Requires Improvement

Is the service caring?

Our findings

People we spoke with told us that staff who worked permanently in the home were kind and caring and that they felt they knew them well. One person said, "They [staff] look after me the best they can, I know a couple of carers quite well, they're on today" Another person told us , "They [staff] are all nice." A further person said, "They [staff] are kind and helpful."

The relatives agreed that the permanent staff were caring. One relative said, "When it's a regular member of staff that I know, they are all very caring and have always supported in a very positive way, when I go home at night I am absolutely confident." Another relative said, "They [staff and management] have given me the support to be able to support [family member]. When I'm feeling miserable staff come and put their arm around me and ask me if there's anything I want. I feel all the regular staff are compassionate and caring."

However, people we spoke with said they did not feel that the agency staff knew them well. The high use of agency staff was a concern for relatives who told us they were worried about the lack of continuity of care. One person told us, "Every time we get an agency person I have to go through it all again, I haven't got any relatives. They [agency staff] couldn't care about you, they just do the job." Another person said, "Most staff are good but the ones from an agency don't know me well."

One relative told us they felt some of the agency staff were not dressed very professionally and that it was difficult to recognise them as staff. Another relative said, "Some agency staff cause me extreme concern, some have been very good and they have the same ones back but there are some issues with other agency staff. It would be better if there were all regular staff." A further relative said, "Poor staffing levels, no continuity of care, they tried their best but there are too many agency staff. If they kept the same staff on the same floor, the regular staff are good with [family member] but when they're not here there's just no continuity."

The staff we spoke with who were all permanent staff working in the home demonstrated that they knew the people they supported. They understood people's likes and dislikes. Some were aware of people's life history and told us they used this to strike up conversation with people that was meaningful to them. They said this helped them build caring relationships with people.

Most staff were seen to interact with people in a polite and caring manner. Some staff were seen getting down to people's level when speaking to them so they could communicate with them well. Other staff were observed to comfort people when they became upset. However, there was a lack of consistency in the caring approach of staff and we saw some examples of poor care practice.

One person was seated at a dining room table by a member of staff. The person was heard to say, 'Oh I am so hot.' However, the staff member did not acknowledge this and walked away. Another person was taken back to their room by a staff member. When we walked past their room we heard them calling for staff who were not around. When we went into their room they told us that the staff member had not left them with the call bell which we passed to them. The same person was taken into the dining room at lunchtime by

staff. They placed the person next to another person they were uncomfortable with. We heard the person say in a distressed manner, "I don't want to sit here, that person scratched me earlier." Although the staff acknowledged this, they did not offer to move the person or provide them with any comfort. The person was seen to remain in a distressed state.

We also saw on occasions, that people's dignity was compromised. We observed a member of staff had left one person's room door open when assessing them for personal care. The person was in a state of undress and could be seen by the inspector and other people living in the home. Another person had pulled their bedclothes off their bed and was showing their nightwear. The door to their room was open. Another person who lived in the home was sitting just outside their room in the corridor and could easily view this. Improvements were therefore required to make sure that people receive care from staff who know them well and who treat them with dignity and respect at all times.

Most people we spoke with said they felt actively involved in making decisions about their care. One person told us, "Yes, I can make my own decisions and they are respected." Another person said, "They have asked me if I am happy and I am."

The relatives we spoke with all told us they felt fully involved in making decisions about their family member's care where it was appropriate. One relative told us, "There are occasions and I feel that I'm asked for my opinion or my agreement is sought." Another relative said, "I have made amendments and signed off the review of their care plan, I think that's the first review we've had in a year, there were inaccuracies that I've put right."

The staff we spoke with were clear about the importance of offering people choice and we saw that most staff did this during the inspection. People were offered a choice of food, where to sit and if they wanted to have their food cut up. However, we saw one staff member tell one person who wanted to eat their lunch downstairs that they could not do this.

The operations support manager had recognised that people and relatives had not always been involved in making decisions about their care. In response to this, they had written to all relatives and introduced a 'resident of the day'. This involved a full care review of one person's care on that day. The person was included within this process as was their relative if required, where the care being reviewed was discussed and agreed. The operations support manager told us that this was working well.

There were several sitting areas on each floor and chairs and tables in suitable locations in some corridors. This provided people and their visitors with a choice of places to sit, eat, drink and relax. We saw people utilising these areas when their relatives visited. There was also access to the secure garden from several locations around the home and we saw some people enjoying the outside space.

Requires Improvement

Is the service responsive?

Our findings

We received mixed views from people regarding whether their individual needs and preferences were being met. One person told us, "At 8:15am in the morning I ring my bell and they come and tell me if they can do me then, or how long they'll be, they're not long. I'm the only one that gets up for breakfast (on this floor)." Another person told us how the staff had responded quickly when they had fallen out of bed. They said, "The nurses came and checked on me. They were very good."

However, two people we spoke with said their preferences and needs were not always met. One person said, "They [staff] did ask me if I wanted a male or female [carer]. I asked for a man but I've never had a man yet!" Another person told us, "They [staff] were supposed to come and shower me, you're just waiting. I normally have breakfast about 8.30am, I'm normally up by then." When we spoke to the person it was after 10am. When asked if they were able to choose the time they got up in the morning and went to bed at night. They said "They [staff] do ask you. They did ask me this morning if I want to get up, but that was this morning and I've been waiting ever since." We alerted staff to this who immediately assisted the person with a shower.

Most of the relatives we spoke with said they felt the staff met their family member's needs. One relative said, "I think generally it has met their needs very well." Another relative told us, "I think the regular staff know what [family member] needs." However, one relative said, "The carers are rushing around, they haven't got time to sit with the residents and give them that extra time."

The staff gave us mixed views with regards to being able to deliver care that was based on people's individual needs. Four staff said this was possible whilst two others said they did not feel they had time to provide people with individualised care.

On the day of the inspection, we saw some staff respond to people's requests for support in a timely manner for example, with personal care or food and drink. One person said they were cold and a cardigan was quickly brought for them. However, the lunchtime meal took a long time to be served which meant people had to wait for it. On the ground floor of the home, people were seated within the dining area 30 minutes before the food was served. On the middle floor, some people had to wait for 40 minutes to receive their food. Some people were observed to become upset and annoyed at this. One person was seen resting their head on the table. This delay to people receiving their food was due to the staff having to wait for the meals to be delivered to the different floors. We also saw that the lack of understanding by some staff of how to meet one person's needs when they became distressed, meant the person did not receive individualised care.

One lifestyle coach who was responsible for providing people with activities was working during the inspection. They told us that there used to be a lifestyle coach working on each of the three floors and a lifestyle lead but that currently there was only themselves and one other to provide activities. The other lifestyle coach was on holiday at the time of the inspection and no contingency was in place to cover for them. The lifestyle coach who was working told us that they tried to provide people with as many activities they could that were meaningful to them. They gave examples of cake baking, arts and crafts and flower

arranging.

They said some people had recently visited a local garden centre and there was an indoor garden area in the home where people could plant vegetables and plants. There was a cafe where people could go and have a cup of coffee and a cinema that the lifestyle coach told us was regularly used by people. However, they added that when they were on their own they could only provide limited activities to people.

Some people were supported to go to other areas of the home for a coffee in the afternoon or outside to get some fresh air. Other people went to watch a line dance demonstration that was being performed. We did observe however, that for most of the morning some people who were living with dementia received little stimulation. During lunchtime on the middle floor, six staff were observed standing in the kitchen area waiting for the food to be delivered from the kitchen. None of them took this opportunity to engage with people who were waiting for their meal.

We spoke with the operations support manager about this. They told us that they were actively recruiting another member of staff to this team and that the provider had given them a budget to increase the number of lifestyle staff if needed. They added that staff were also expected to engage with people in activities. However, we saw that staff had limited time to do this.

People's care needs had been assessed prior to them moving into the home. However, not all people's preferences regarding how they wanted to be cared for had been gathered. The operations support manager told us they were aware of this and that plans were in place to improve the capturing of this information.

Following the assessment of people's needs, plans of care had been developed to provide staff with guidance on what care people wanted to receive. These plans of care were both accessible electronically and via paper format. We found however, that the paper format did not always include all of the information that was in the electronic plans. Although a summary was within the paper care records of the care people required, this did not have information about how to reduce risks to people's safety. This was important as the operations support manager told us that this was an aide for the agency staff to help them understand the care that people required.

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

We received mixed views from people about whether they knew how to make a complaint if they felt they needed to. One person told us, "No, I don't really know who to speak to." However, another person told us, "I haven't any complaints yet, only minor things that were sorted out."

We also received mixed views from relatives. One relative told us positively, "For six or seven days they had chicken on the menu. A number of people complained and they have now changed it, when the regional chef is here it's a whole lot better." We spoke to the operations support manager about this who showed us they had requested feedback from people about the quality of the food as they were aware of a number of complaints. In response, people had been consulted about what they wanted on the menu and new menus had recently been issued.

However, another relative told us, "We have complained and the staff responded for a few days. The manager does try to change things but it doesn't last. At the moment [manager name] is the person to speak with." Another relative told us, "If I had an issue I always raise it with the management. If they say "leave it with us", they'll do nothing, if they say "we'll have a word" then the carer gives you a scowling look the next

day."

Both verbal and written complaints were recorded. The home had received 11 compliments and 17 complaints within the last 12 months. We looked at two complaints in detail. These had been thoroughly investigated by the provider and a meeting held with the complainants. We were therefore satisfied that people's complaints were dealt with but that improvements were required to make sure that people understood how to complain if they wanted to.

Requires Improvement

Is the service well-led?

Our findings

During this inspection, we found a number of issues regarding the care that was being provided to people who lived at Cavell Court. Therefore the current systems in place to check the quality and safety of the care provided were not always effective.

Although the operations support manager had identified the need to regularly check that people received their medicines correctly, we found gaps in both the oral and cream medicine administration records. This indicated that people may not have received these medicines. Therefore the current system for checking medicines was ineffective. The operations support manager told us after the inspection visit they had spoken to the staff involved and that these checks had been increased.

The operational support manager acknowledged staff had historically not been deployed effectively around the home to meet people's needs, particularly when it first opened in July 2015. They told us the way people had been admitted to the home had been poorly planned which had contributed to people receiving poor quality care. Plans were in place to rectify this which the operations support manager was confident would resolve any issues in relation to staff not being available to meet people's needs in a timely manner.

Some training of staff had not been completed when required or was overdue. This had been recognised as an issue by the provider in March 2016 but sufficient action had still not been taken at the time of this inspection to correct the situation.

The provider had noted that some staff had not received any formal supervision since the beginning of 2016. However, no action had been taken in relation to this until May 2016 when the senior staff were placed on supervision training so they could provide staff with supervision. A report we received in March 2016 from the local clinical commissioning group recorded that they had been told that staff supervision had taken place every six weeks. However, this had not been the case.

The provider's current systems to check the safety of the home had not picked up the risk of the hot kettle being used on the floor where people were living with dementia.

The operations support manager had gained feedback from people about some aspects of the care they received. This included the food and the activities on offer. Action had been taken in respect of the improvements people requested in relation to the food they received. However, people's suggestions on how to improve activities which had been received in April 2016 had not been implemented. For example, one person had requested that representatives of various faiths be invited into the home to help people practice their chosen faith. The lifestyle coach told us they were aware of this but had not yet explored the issue. Therefore, although people's views about their care had been captured, action had not always been taken in response to these.

The inconsistency between the two sets of care records in use had not been recognised. The electronic records contained sufficient detail for staff to follow but the paper records did not. Due to the high use of

agency staff, this increased the risk of people receiving unsafe or inappropriate care.

On the day of the inspection, there was either a team leader or nurse on each floor who provided guidance to the staff who were working in that area. We did however see that staff were not always given good direction or leadership. For example, one lunchtime was observed to be chaotic with a lot of staff gathering in one area and chatting. They were confused about who required what food and there was a lack of direction from the team leader about who needed to do what. This resulted in people not receiving their meal in a timely manner. The team leader was observed prompting someone to eat their meal but then was called away. They did not allocate another staff member to this task so the person did not eat much of their meal.

Some staff were observed to use poor care practice. The senior staff were not on the floor to observe this so they were unable to address these issues for the safety of the people involved.

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

A weekly clinical meeting had recently been introduced. At this meeting, people's individual needs such as nutrition, hydration and pressure care were discussed. The deputy manager told us this was so they could refer people for specialist advice quickly if needed.

There was no registered manager working at the service. The last registered manager left the home in April 2016. A new manager had recently been recruited but had not commenced working at the home at the time of our inspection. In the interim, the home was being managed by the provider's operations support manager with support of other representatives from the provider.

We received mixed views from people as to whether they felt the home was managed well. One person told us, "Oh yes, it is an excellent place to live." Another person said, "I have spoken to the manager, very approachable." However, another person said, "There is a manager but I haven't spoken to them, I don't know who they are."

Relatives also had mixed views. One relative told us, "This is an excellent place, it is managed very well, it is all about the care." Another relative said, "They need a leader who is attached to this home, I understand they've appointed someone. I get the impression that [temporary manager] is a very responsible person." Another relative however said they felt the home had not been run very well and that they had not seem much improvement in the care being provided. They told us, "There needs to be a much more heavy handed management to deal with the issues here." A different relative said they did not feel that the staff worked very well as a team.

All of the staff we spoke with told us they felt the home was well led but some said they would welcome a permanent manager. Most of them were clear about their individual roles and responsibilities. However, two to them said they sometimes felt they lacked direction depending on who their senior member of staff was.

The operations support manager told us they had recognised these issues and that all senior staff working at the home had commenced leadership training. A new clinical lead has also recently been employed at the home. The operations support manager was confident that this would improve the leadership within the home. The staff said the current management team were approachable and listened to any concerns they raised.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The care and treatment provided did not always meet people's needs and reflect their preferences. Not all people's preferences had been assessed and the care had not been designed with a view to achieve service users preferences and ensuring their needs were met. Regulation 9 (1) (3) (a) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Care and treatment was not always provided in a safe way and action was not always taken to mitigate risks. People's medicines were not managed safely.Regulation 12 (1) (2) (b) and (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Effective systems and processes were not in place to assess, monitor, and improve the quality and safety of the care provided or to mitigate risks to people's safety. Feedback from relevant persons had not always been acted on. Regulation 17 (1) (2) (a) (b) (c) and (e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received appropriate support,

Treatment of disease, disorder or injury	training, professional development, supervision or appraisal as is necessary to carry out the duties they are employed to perform. Regulation 18 (1) and (2) (a).