Cedar Court (Cranleigh) Care Limited

Cedar Court Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

Cedar Court Care Home is a purpose built care home that provided accommodation, nursing care and support for up to 75 people. There were 61 people living in the home on the day of our visit. It has a designated unit that specialises in the provision of care for people living with dementia. Accommodation is arranged over three units. Albert unit provides nursing care for 30 people, Edinburgh unit provided care for 29 people living with dementia, and Alexander unit provides support for 8 people who do not require nursing care.

The home did not have a registered manager in post on the day of our inspection. A registered manager is a person who has been 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 service is run. There was manager in the home who was not registered with CQC.

Summary of findings

Some people told us they were treated well by staff who were kind and caring. People's privacy and dignity was not always maintained. We noted one person wished to have gender specific staff to undertake personal care but this was not always possible due to deployment of staff.

We saw staff knocked on people's doors before they entered.

Not all staff had undertaken training regarding safeguarding adults and were not aware of what procedures to follow if they suspected abuse was taking place. There was a copy of Surrey County Council's multi-agency safeguarding procedures available in the home for information but staff did not always know what role the of the local authority was.

Assessments were not always in place where people had an identified risk. For example a person was required to have thickened fluid but the home had run out of this which meant they were at risk of choking when they ate or drank.

People were not satisfied with the standard of cleanliness in the home and we found that some areas of the home were dirty and unhygienic. One person told us "My bin has not been emptied for two days."

Care plans were not always easy to follow and information was not always reviewed and kept up to date. For example a diabetic care plan had not been maintained and the last record of the person's blood sugar levels was over seven months previously.

People's health care needs were being met. People were registered with a local GP who visited the home weekly. Visits from other health care professionals also took place.

People had sufficient food and drink to keep them healthy however mealtimes were not always a positive experience for people living with dementia. Some people had to wait before they were served their food and people identified as being at risk of malnutrition were not always monitored to ensure they were maintaining their weight.

We looked at the medicine policy and found all staff gave medicine to people in accordance with this policy. Medicines were managed safely and people received their medicine in a safe and timely way.

There was not enough staff working in the home to meet people's needs. People sometimes had to wait for care to be provided as the correct number of staff was not available to undertake this. The laundry person had left without warning the previous week and the activity coordinator was undertaking the laundry duties on the morning of our inspection. This impacted on the amount of activities available.

Staff recruitment procedures were safe and the employment files contained all the relevant checks to help ensure only the appropriate people were employed to work in the home.

People were engaged in activities during the afternoon on the ground floor. No activities were taking place on the dementia unit and we saw people wandered about the unit unoccupied.

Systems were not in place to monitor the service being provided. We were unable to see any audits of care plans risk assessments or health and safety audits when we asked for them.

People had been provided with a complaints procedure, however we were unable to see the complaints log to monitor the amount of complains made in the service since we last visited. However we had received concerns regarding the staffing levels, the management arrangements, and the staffing levels in the home prior to our visit.

The home was not being well managed. People said they found the manager not easy to talk to and when they had concerns regarding staffing and the standard of cleanliness the did not act on their concerns.

The standard of record keeping was poor and not maintained to an acceptable standard. For example care plans were not always reviewed, cleaning schedules were not kept up to date and risk assessments were no always in place for identified risks.

The overall rating for this report is 'Inadequate'. This means that it has been into 'Special measures by CQC. The purpose of special measures is to;

- Ensure that providers found to be providing inadequate care significantly improve.

Summary of findings

- Provide a framework within which we use our enforcement power in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such as there remains a rating of inadequate for any key questions overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the providers registration.

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

Summary of findings

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 staff available to safely meet people's needs which meant that people had to wait for care to be provided.

The standard of cleanliness and hygiene in the service was poor and there were no arrangements in place to monitor the cleaning.

Risks to people were not managed well and staff were not always aware of the assessments in place to help prevent avoidable harm.

Not all staff had a clear understanding of how to protect people from the risk of abuse and the procedures to follow where abuse was suspected.

Medicines protocols were effective and people received their medicines safely and according to their medicines plan.

Is the service effective?

Inadequate

The service was not effective.

The provider and staff did not have a good understanding of the Mental Capacity Act 2005 and some were having their liberty restricted with the use of stair gates on their doors to prevent other people from going in their rooms or stop people from wandering.

Staff did not have the appropriate training to meet people's needs and were not had received adequate supervision.

People received adequate nutrition and hydration, however food was not always served in a timely manner and some people had to wait over thirty minutes for support with eating.

The environment for people living with dementia was not appropriate for them.

Is the service caring?

Requires improvement

The service was not always caring.

People were not always involved in decision making. Someone wanted to go out but was unable to because there were not enough staff to take them.

People were not always treated with dignity and respect and people were not responded to promptly when they needed help.

Privacy and dignity was not always maintained as the service was not able to provide gender specific staff to people who wanted this.

Staff spoke with people in a polite and kind way and were looked after by a staff team who were caring and kind.

Summary of findings

Is the service responsive?

Requires improvement 

The service was not always responsive.

People did not receive personalised care that was responsive to their needs.

People's concerns and complaints were not listened to and not responded to according to the complaints procedure in place.

Some people were encouraged to participate in activities; however we did not see activities provided on the dementia unit.

Is the service well-led?

Inadequate 

The service was not well led.

Staff felt unsupported by the manager which affected their morale.

There were quality assurance processes in place however these were not effective and had not found any of the issues that we identified in our inspection.

Records were not always accurate or completed in a clear way.

Cedar Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 was an unannounced inspection, which took place on 4 June 2015. The inspection team was made up of three 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. The expert had experience in caring for someone living with dementia and older people.

Prior to the inspection we reviewed the information we had about the service. This included information sent to us by the provider in the form of notifications and safeguarding adult referrals made to the local authority. A notification is an account of significant events that occur in the service. We did not ask the provider to complete a Provider information return (PIR).

During the visit we spoke with 14 people, six family members, eight staff, the hairdresser, the manager and the nominated individual. We looked at eight care plans, eight risk assessments, four staff employment files and records relating to the management of the home including audits and policies. We also spoke with two health care professionals following our visit to gain their view about the service that was provided.

Not everyone was able to communicate with us so we spent time observing the interactions between people and staff. We also spent time on the three units observing how care and support was provided.

The last inspection of this home was on 29 July 2014 where we found concerns relating to safeguarding.

Inadequate

Is the service safe?

Our findings

People and relatives told us that there were not enough staff available to safely meet their needs. One person said "There are not enough staff I always have to wait". Another person said when they used their call bell staff told them "You should be in your bed I haven't got the time to help". One relative said the service was "Severely understaffed". They said that call bells took "Ages" to be answered and on occasion it took 30 minutes for their family member's call bell to be answered. We saw that throughout the day the call bells were taking a long time to be answered by staff. Some people did not have access to a call bell because these were either out of their reach or the cord was tied up. This meant that they were unable to call for help when needed. We saw two examples of this during our inspection. One person called out continuously for help for a period of around ten minutes before we asked a member of staff to assist as the person could not be heard. When we asked the manager to show us the call bell print out record they said they do not keep record of this.

They were not enough staff to meet people's needs. We saw several examples where people's needs were not met in a timely way. One person was not supported with their personal care and was left in wet clothes for around 30 minutes because there were not enough staff available to assist them. One person was anxious and kept asking to go into the garden for a walk but was told by staff that there was no one available to take them. We also saw several people had to wait for long periods of time before they were supported with their meals which caused them anxiety.

Staff told us there were not always enough of them to support people but others said they thought there were enough. One told us said "Today we have had to sacrifice someone to help downstairs, I feel people's needs are not getting met." Another said "We cannot do our jobs if there are not enough staff, staff get borrowed to cover other floors." And another told us there were "Always problems with staff". The nursing and dementia units had one nursing staff and three care staff working on them and there were two care staff working on the residential unit. However we found that staff were 'borrowed' from each unit on the day of the inspection to cover staff absence. Where staff were off at short notice or off sick we found the shortfall was not always covered. One member of staff worked over two of the units in the afternoon of our inspection which impacted on the quality of care people received. We found that three people on the residential unit required support with moving and transferring with use of a hoist this took two staff which left other people unsupported. Staff said that they had reported to this to manager but this had not been addressed.

The home was not retaining staff and several had left or were planning to leave.

Some staff said "there were enough staff" but several others said there were not enough staff and people had to wait for care. .

A health care professional told us they thought that the service was understaffed and when they visited staff did not always have the time to help when they needed to see people. The registered provider told us they thought there were enough staff to meet people's needs however staff had left or were planning to leave.

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

There was a safe recruitment process in place and the required checks were undertaken before staff started work. We looked at staff employment files and noted that staff had been recruited safely. This included two written references, a past employment history, a health screening questionnaire and a satisfactory Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

People were not protected by the prevention and control of infection. There was a risk of cross infection. We received concerns before the inspection that the service was unclean and had been closed twice due to outbreaks of infection. We found that areas around the home were dirty and there was no one responsible for the cleanliness of the service as the head of housekeeping and laundry assistant had both left. Laundry duty was completed by staff which took them away from their other responsibilities. We found full bags of soiled laundry in the bathrooms and the laundry room and they remained there throughout the day. There was a sink in the laundry room which had dirty slippers left in it and there was no separate area for staff to wash their hands which increased the risk of cross infection.

Inadequate

Is the service safe?

Other areas of the home were dirty we found peoples chairs and furniture were stained with food debris and some beds were soiled and left unchanged. There was a small kitchen on the dementia unit which people had access to which was dirty with stained walls. The main kitchen was dirty and we found food trollies were dirty with grease on them as they had not been cleaned. There was a fly trap with dead flies on. The manager told us that there was no one responsible for the prevention of infection control and no audits had taken place to monitor the cleanliness. There was no clinical lead in the service to address infection control responsibilities which meant that people were at risk because the service was not being maintained to an acceptable standard of cleanliness.

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

Although there were risk assessments in place for people these were not always being followed. Plans were drawn up with guidance for staff to follow in order to keep people safe. However we found that this was not always happening. One person was at risk of choking and had a management plan in place to reduce the risk. This included fork mashable food and thickeners in their drinks. We saw on three occasions drinks were not thickened and the meal served was not fork mashable. Staff told us they had run out of thickener which meant the person was at risk of choking. We told the manager about this who assured us he would address our concerns. Another person was at risk of developing pressure ulcers due to the poor condition of their skin. The risk assessment detailed what staff needed to do to help prevent this occurring which included the person having their feet elevated and sitting on a pressure cushion or mattress. We found that this person did not have their feet up throughout the day and the cushion they were sat on was not pressure relieving. At one stage the cushion they were using had to be removed completely as it was wet which meant they were at increased risk of developing a pressure sore.

People's risk assessments were out of date and where they had been reviewed there was little information or detail available about the review. One member of staff told us that they did not read people's risk assessments as they had never been asked to and relied upon other staff telling them.

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

People were not always protected from abuse. We saw that there were people on the top floor with child gates on their bedroom doors. Staff told us they this was to prevent other people "wandering" into their room as these people did not feel safe. Their relatives also told us that they did not feel their family members were safe because of this. Not all staff understood what they needed to do in relation to safeguarding people from abuse and not all had received appropriate training or were able to recognise the signs of abuse. Staff were not clear of the role of the local authority in relation to keeping people safe from abuse or how to contact them should an incident occur.

This is a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People received their medicines safely. There was a policy in place for medicines administration. Staff who had responsibility for the administration of medicines had signed this policy indicating they had read and understood this. Staff had received training in medicines safety awareness which was updated annually. Medicines were stored safely and securely on the individual units. A fridge was available for medicines that had to be stored below room temperature, for example insulin, eye drops and creams.

Appropriate arrangements were in place in relation to the recording of medicines. The service used the medication administration record (MAR) chart to record medicines taken by people. We noted appropriate codes were used to denote when people did not take their medicines.

For example if they refused, if they were on leave or in hospital. The MAR charts included information about people's allergies, if they required PRN (when required) medicines and a photograph for identification. The majority of medicines were administered using the monitored dose system (MDS) from blister packs which made it easier to see if medicines had been missed.

Appropriate arrangements were in place in relation to the safe monitoring of medicines.

Inadequate

Is the service effective?

Our findings

People were not supported by staff with the skills and training needed. The training records provided were not clear and we could not establish which staff had the training they needed to fulfil their role as records were incomplete. Staff inductions were not always followed, one member of staff told us their induction lasted two days which did not adequately prepare them for the job they would be doing. Another said they had not received essential training in how to move people safely and relied on other staff giving them guidance.

Staff told us they did not have regular supervision with their line manager to assess their strengths and weaknesses and were not given the opportunity to address issues or concerns as a result.

One member of staff told us they had asked for supervision on a number of occasions but had been told there were "Other priorities". They said that they had "No concerns" with the care they provided but said they needed to be a "Quality review". The manager told us that there had not been any supervisions or one to ones with staff that year because they were "Too busy".

Specialist training to meet people's complex needs had not been provided to staff. For example not all staff had not received training in dementia and as a result had a limited understanding of how to support people living with this condition and what this meant for people.

There was no evidence that updated clinical training had been provided to nursing staff. This meant they would not have the most up to date guidance to provide the most appropriate care. An experienced member of nursing staff was leaving shortly after our inspection and were to be replaced by a newly qualified member of staff. As there was no clinical lead at the service and none of the managers were providing clinical supervisions there was a risk that this new member of staff was not going to have the support they would need.

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

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The manager was aware of the changes in DoLS practices and had policies and procedures regarding the Mental Capacity Act (MCA) 2005 and DoLS. Where people lacked capacity to make some decisions the MCA assessments had not always been completed appropriately. For example, some people had stair gates on their bedroom doors. There was no evidence that a MCA assessment had been completed to look at whether the person could consent to this. Some care plans included 'best interest' discussions but there was no evidence of an assessment of people mental capacity. We saw examples when some staff asked people's consent before they undertook tasks such as "Would you like to sit to the table for lunch" or "Do you need the bathroom before you have lunch". Other times staff did not always have time for people and we heard a staff member said "Sit down and we will come when we are free".

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People spoke very highly of the chef and said "Things have vastly improved since he commenced employment".

People who were able to told us they liked the food and said the chef "Tailors the food more and has given us more of a choice" and we saw people were provided with drinks and snacks throughout the day. The chef introduced himself to a new person and asked them about the food they liked. Menus were planned over a four week period which were being reviewed by the new chef who had recently started.

The mealtime experience for people with dementia was quite different to those on the nursing and residential units. Tables were nicely laid with linen table cloths and condiments and cutlery were provided. Drinks were also available. People living with dementia were not offered a choice of what to eat by staff and their meals were put onto plates for a long time before they were offered to them which meant some meals were served cold. When people were served their dessert of crumble and custard by the time it was given to them there was thick skin formed over it which did not make it look appetising. Some people sat at their tables for extended periods without being prompted to eat by staff and as a result we saw one person fall asleep. Staff told us the mealtime experience for people was "Normal".

Lunch on the residential unit was a pleasant experience for people, tables had been laid out in a restaurant style and

people were offered wine with their meal which they clearly enjoyed. People could choose where they ate their meals with some having lunch in their rooms and the meals were served in a timely way so that they were still hot.

We saw people on the nursing unit were served lunch in the dining room or in their bedrooms. Food was taken from the main kitchen in heated trolleys and served in the dining room, and taken to peoples rooms on trays. Pureed food was presented well and we saw one person who required support with eating was given this by staff although they sometimes had to wait half an hour after the food was served before help became available. We saw another member of staff was sitting supporting a person to eat and they were doing so at a pace that was right for the person. This support was agreed in a care plan and was being paid for by the person's family.

Some people were at risk of losing weight and as a result there were Malnutrition Universal Screening Tools (MUST) in place so that the risk to people could be managed. Two MUST assessments were out of date and had not been reviewed since November 2014. People's weight was monitored regularly and the results recorded so that appropriate action could be taken should people lose weight however two people had lost weight and no action had been taken by staff and the matter had not been referred to the GP or speech and language therapist for further guidance.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People's healthcare needs were not always managed well and relatives told us that, although nursing staff kept them informed about their family members health, they were concerned about what was going to happen when the registered nurse left. They told us "They lose all their good staff here, and it's not good". One person should have had regular physiotherapy as part of their treatment and rehabilitation plan but this had not been happening. Another person was diabetic and needed to have regular blood sugar monitoring but there was no record that this had been done since October 2014, there was no diabetic care plan in place to help guide staff.

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

People had regular access to chiropody, dental care and eye care and people could either access this in the community or home visits were arranged. Staff told us that everyone was registered with a local GP who visited the service weekly or more frequently if required to do so. People who were able to told us they could see the doctor when they needed to and if they required additional support for example consultant intervention this was arranged by their GP.

The home advertised that it provided dementia care. The dementia unit was located on the first floor and had lift access but the environment was unsuitable for people living with dementia. It was dark; the carpets were patterned and not suitable for people who were prone to falling. There was no appropriate signage for example memory boxes or some form of identification that would prompt people that was their own room, which meant that people wandered in and out of other people's rooms in confusion. There were no appropriate signs on bathroom doors encouraging people that could to be independent. We saw electric hand dryers in the bathroom which people with dementia could not associate with hand washing and we saw people leaving the bathroom without washing their hands. Some rooms were not personalised and had little atmosphere. Communal areas lacked objects that would stimulate people such as rummage boxes.

This a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Requires improvement

Is the service caring?

Our findings

Some people told us they were very happy living in the service and said "It suits my circumstances". Others told us they were not satisfied living in the service. One relative said the service was "Deteriorating". People told us staff were kind and caring. One person said "The staff are marvellous" and another person said "The staff are excellent and could not want for better". A relative said " We have good quality staff but not enough of them".

We were able to see from observations and from our interactions with people that not all were content living in the service. In the dementia unit on the first floor people were walking around alone or stayed in their rooms. Staff did not always interact with people which meant that living on the unit was not always a pleasant experience for them. We heard one person calling out from their room as they had dropped some food on the floor. We saw that they were sitting in wet clothes as they had not been able to get to the toilet in time. Staff responded to this after 15 minutes and changed their clothes however they changed the person into night clothing in the middle of the afternoon which did not promote their dignity.

Although staff tried to provided care and support in a kind and caring way they did not always have the time to spend with people and interact with them. Care was task orientated and staff were rushed doing additional duties which impacted on the level of care they were able to provide. For example they had to wash up, clean floors and lay tables in the absence of any domestic staff. We saw a person wandering around seeking attention. A member of staff said "People get bored and we don't have enough staff up here to look after people properly, they end up throwing things at the window as they want to go out". Staff told us they had told the manager on several occasions about the problems but nothing ever got done and that they seldom visited the unit. Staff did not always encourage people who required prompting to drink and we saw some people had the same drink in front of them for over two hours.

People's privacy and dignity was not always respected. A member of staff told us there was one person who only liked to have gender specific staff to undertake personal care. They said this was not always possible due to staffing levels and sometimes when staff were not available they were not able to meet this request. They also said there were occasions when the allocation of incontinence pads and pants had "Run out" and it was necessary to borrow from other people. One member of staff said "How is it possible to provide basic care when we do not have the most basic of equipment to preserve people's dignity and respect". Another told us "I am leaving soon as I do not like the way people are treated here" "People pay a lot of money to live here it's not good".

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Some people chose to have their doors open and others closed. Staff knocked on bedroom doors and waited for a reply before entering, which helped to maintain people's dignity. People were encouraged to bring ornaments and photographs into the home to make their bedrooms more personal to them. Relatives told us they were welcome in the home at any time and encouraged to help personalise their family member's bedrooms. They said there were private areas where they could visit their family member and speak without being overheard.

People on the residential unit and nursing unit were encouraged to make choices about their daily routines. Some people chose to spend time alone and participate in activities they liked. One person said "I can sit in the garden which is glorious and peaceful in the good weather".

Requires improvement

Is the service responsive?

Our findings

People had assessments undertaken before they were admitted to the service in order to ensure there were the resources and expertise to meet people's needs. Some people told us that staff from the service came to visit them in hospital and asked them several questions about their health, what they liked, and what mattered to them. Relatives told us they had been involved in part of the assessment especially with their family member's life history which helped build a picture of what the person was like. The assessments we looked at were varied but not all of them included peoples past life experiences. This did not provide staff with relevant background knowledge about the person they were caring for which would have helped promote conversations with them.

People had care plans in place but the quality of these was varied. Some were hand written and some had been typed which were easier for people and staff to read. Each care need was supported with a plan of care and objectives to be achieved. The reviews of care were limited with very little information other than 'no change' noted with the date added. One person's care plan identified that they were at risk of developing a pressure ulcer but no air mattress or pressure cushion had been provided. Another care plan stated that the person must have their feet elevated during the day to reduce swelling. At no point during the day did they have their feet up and their legs were swollen as a result. Staff did not always recorded daily entries in the care plans about how care was delivered on each day and how that person was feeling and if they had any visitors either family or health care professionals. Staff told us they did not have time to read people's care plans.

There was an activities coordinator employed in the service and they took the time to demonstrate the range of activities provided. There were several photograph albums in the front hall showing all of the outings and events that had been undertaken. The service had a mini bus and organised trips out with volunteers to local places of interest like Kempton Park racecourse, Denbies vineyard and Brooklands Motor Museum. They said they had good links with local schools who visited the service regularly. Other in house activities for example music and exercise, art and craft and a variety of games were also available.

On the day of our visit the activities coordinator was undertaking the laundry in the absence of laundry staff which impacted on the amount of stimulation and activities being provided during the morning. The only activity we observed was a quiz in the afternoon which was taking place in the lounge on the ground floor. Staff said there were no one to one activity for people who were bed bound and the activities coordinator confirmed this. People who were kept in their rooms with the use of child gates were at risk on social isolation and there was nothing to demonstrate they took part in any activities. People told us they liked all the activities provided and spoke highly of the activities coordinator.

People's spiritual needs were observed and visits form various clergy were arranged on request. A church service was organised every week which also included Holy Communion for people who wished to attend.

People knew how to make a complaint or comment on issues they were not happy about. People and their relatives were provided with a copy of the complaints procedure when they moved into the home. There was also a copy of this displayed in the main entrance. People said they were not happy with how complaints were managed. We were told by relatives when they made a complaint about something they felt the manager did not handle this very well. One person asked for an individual activity but was told this would be too costly. A person complained about the staffing levels and the lack of regular staff who knew their needs, but said the manager did not act on this. Another person complained about the standard of cleanliness and said it got better for a little while but then the cleaners left again.

Inadequate

Is the service well-led?

Our findings

The home was not being managed well and had been without a registered manager since March 2014. The home was being managed by someone who had submitted an application to us to become registered. People were not happy about the management arrangements in the home. There were concerns raised by the relatives, people who used the service and staff as to the quality of the management. In particular comments were raised about their inability to recruit and retain good staff. People also said the manager was not visible enough and did not initiate conversation with them. A relative said "I never see the manager, he is always in the office".

Staff felt unsupported by the management arrangements that were in place and said the manager was not approachable and did not listen to some of the concerns they had. One member of staff said "We have told them on several occasions we are unable to meet people's needs but it is just ignored". Another said "Staff morale is quite low. We usually have our salaries reviewed every September but it didn't happen last year and no one has communicated why". Staff said there were no team meetings which meant they were not kept up to date with what was happening in the home or able to raise concerns that they may have. Staff supervision had not been provided regularly and staff appraisals were not in place which impacted on how staff were feeling and did not improve their morale.

The manager told us they got "Little support from above" and had no deputy or senior staff to delegate some responsibility to. They told us they felt unsupported by the provider and that although they knew the faults in the home they felt restricted from developing the home or making improvements. The nominated individual who is also the area manager visited the home weekly to support the manager.

Relatives told us they were kept informed about their family member's care and any changes that took place by the staff on the units. One relative said "I am worried about the lack of senior staff in the home and the worrying turnover of good staff, and the impact this will have on care". Another relative said "It's not all bad they have a wonderful activity person".

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

The provider did not have adequate systems in place to monitor the quality of the service. Heads of department meetings did not take place which meant there was little communication between staff to monitor the service provision. The standard of record keeping was inconsistent and not up to date. Reviews of care plans and risk assessments were not always undertaken in a timely way which meant staff would not have the most recent information and guidance in relation to individual's care. Health and safety audits, infection control audits and housekeeping audits were not up to date and the issues we found during our inspection had not been identified as part of the quality assurance process.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. The provider had not informed the CQC of all significant events that happened in the service in a timely way. This meant we were unable to check that the provider took appropriate action when necessary.

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

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **People were deprived of their liberty because child gates were used as a form of restraint.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **People did not have capacity to consent to the use of child gates and did not have mental capacity assessments in place.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **People's needs were not being met because there were not sufficient numbers of qualified, competent and skilled staff employed in the service.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **People were at risk of infection because the provider did not maintain a satisfactory level of hygiene in the home, kitchen and laundry.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Action we have told the provider to take

The provider did not have risk assessments in place for identified risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff did not receive appropriate support, training, professional development, supervision and appraisal as necessary to enable them to carry out their duties they are employed to perform.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs People were not supported to eat and drink.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People were not treated with respect because gender specific staff were not always available to undertake personal care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The premises must be fit for purpose and designed to meet the needs of people living with dementia.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

The service did not monitor and improve the quality of the service provided.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.