Hayworth Care Limited

Cathedral Nursing Home

Inspection report

23 Nettleham Road
Lincoln
Lincolnshire
LN2 1RQ

Tel: 01522526715

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We undertook a comprehensive inspection on 20, 21 and 28 February 2018. The inspection was unannounced.

Cathedral Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service is registered to provide accommodation for up to 38 younger adults, older people or people living with a dementia type illness. On day one of our inspection there were 29 people living in the service.

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

This was a first inspection for the service under the new registered provider Hayworth Care Limited. At this inspection we found that the service was rated, 'Inadequate'.

We found five breaches of the regulations. This was because the registered provider failed to ensure that there were systems and processes in place to assess, monitor and improve the quality and safety of the service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their

registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

There was not always enough staff on duty with the right skill mix to keep people safe and respond to their care needs in a timely manner. People were at risk of harm from poor infection control practices and environmental issues. There were uneven floors in public areas, some areas were poorly lit and fire risks in the laundry were not identified or managed. Medicines management was not always practiced safely.

The provider followed national guidelines to lawfully deprive a person of their liberty. Care staff did not follow national guidelines when obtaining consent from people or record that they had acted in a person's best interest. Care staff were not supported to read people's care plans and often worked on their own initiative without supervision and leadership. People were not always provided with their choice of food.

People and their relatives were not involved in planning their care. Care was not person centred, but was task orientated and followed ritualistic practices. Staff had little insight into the needs of people living with dementia. The premises did not support their individual needs. Staff did not always treat people with privacy and dignity.

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

People had access to a complaints procedure; however, most people would have difficulty reading it as the print size was small. Complaints were not always resolved in a timely manner. The service was supported by a community frailty team to provide end of life care, but staff did not always contact them in a timely manner so as they could be appropriately supported at the end of their lives.

There was a lack visible leadership and effective role models to support inexperienced staff. A range of audits were undertaken, but the outcomes did not lead to improvements in practice.

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 was not enough staff on duty with the right knowledge and experience to keep people safe.

Staff did not always follow safe infection control practices.

People were at risk of harm from uneven floor surfaces, poor lighting and the risk of fire.

Is the service effective?

Requires Improvement

The service was not effective

Care staff did not read care plans before they delivered care to people and the delivery of care was not coordinated.

Staff did not always obtain consent from people or follow the guidance laid down in the Mental Capacity Act 2005.

Referrals were made to lawfully deprive a person of their liberty.

Is the service caring?

Requires Improvement

The service was not caring.

People and their relatives were not supported to be involved in planning decisions about their care.

People were not always treated as an individual, but as a job to be done.

Staff did not understand how to treat a person living with dementia with dignity and compassion.

Is the service responsive?

Inadequate

The service was not responsive.

People did not always receive personalised care that was

responsive to their needs.

People had access to a complaints procedure, but complaints were not always resolved in a timely manner.

The service provided care to people at the end of their life.

Is the service well-led?

Inadequate

The service was not well-led.

There was little evidence of visible leadership and good role models to support inexperienced staff.

There was not a clear vision to deliver high quality care and promote a positive culture.

Audits were undertaken, but there was little evidence of lessons learnt from these.

Cathedral Nursing 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 inspection was not due for another eight months. However, we were prompted in part to inspect now in response to concerns raised following the death of a person in hospital who had recently been cared for by the service. Furthermore, we had received several concerns from the public and members of staff, past and present about a high staff turnover and poor standards of care.

The information shared with CQC indicated potential concerns about the management of the risk of falls, a high staff turnover, safe staffing levels, higher than expected safeguarding alerts and the identification and treatment of sepsis. This inspection examined those risks.

This inspection took place on 20, 21 and 28 February 2018 and was unannounced. On the first day of our inspection the inspection team was made up of two inspectors and a specialist advisor, whose specialism was nursing care and older people. On the second and third days of our inspection the inspection team was made up of two inspectors.

Cathedral Nursing Home was registered in August 2017 under a new registered provider, Hayworth Care Limited. At our last inspection of Cathedral Nursing Home on 17 January 2017 the service was registered under South Yorkshire Care Limited and was rated 'Good'. At this inspection we found the recently registered service was rated 'Inadequate'.

Before our inspection we gathered and reviewed other information we held about the service such as notifications (events which happened in the service that the provider is required to tell us about) and information that had been sent to us by other agencies including the local authority contracting and safeguarding teams.

During our inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of

observing care to help us understand the experience of people who could not speak with us. We spoke with the registered manager, the deputy manager, the provider, the administrator, a registered nurse, four members of care staff, the cook, two housekeepers, the laundry assistant and nine people who lived at the service. We also spoke with five relatives and three visiting healthcare professionals. In addition we looked at several areas of the service including shared areas, two medical rooms, the laundry, the upstairs and downstairs sluice, shared and private use toilets and shower rooms and all bedrooms.

Due to the short notice of our inspection visit, we did not have time to request a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made judgements in this report.

We looked at a range of records related to the running of and the quality of the service. These included three staff recruitment and induction files, staff training information, meeting minutes and arrangements for managing complaints. We looked at the quality assurance audits that the registered manager and the provider completed. We also looked at care plans and daily care records for 12 people and medicine administration records for 29 people who lived at the service.

Inadequate

Is the service safe?

Our findings

There was little evidence of risk assessments for the internal and external environment and several areas of serious concern were identified relating to infection control, fire risks and environmental issues.

We brought to the registered manager's attention that the laundry was unsafe and there was a risk of fire. There was inadequate ventilation, the internal walls were damp and plaster was crumbling off them. There was a build-up of fluff on an air vent and behind the washing machines and tumble dryer there was a build-up of fluff, litter and rubble. We have reported our concerns about the fire risks to the Lincolnshire Fire Safety team.

We identified several avoidable hazards. Some first floor windows did not have window restrictors in place. In the lounges and corridors some overhead light bulbs were not working and the lighting was poor. There were uneven floor surfaces in communal areas and corridors and this increased the risk of falls. There was no signage warning of these hazards. The hazards we observed posed a significant risk of harm particularly to people who were frail, lacked spatial awareness or has difficulty mobilising.

The deputy manager told us that there were a number of different airflow mattresses in use and that guidance on their use was recorded in individual care plans. However, care staff would be unable to follow the guidance as they did not access care plans. Failure to set the mattress correctly could cause injury to a person's skin.

We found that where risks were identified through audit that immediate action was not taken to safeguard people. We saw a copy of the annual health and safety audit undertaken in December 2017. Two of the issues identified were that fire doors were wedged open and foot operated pedal bins were required. We found similar concerns, such as the office fire door automatic closure mechanism was broken and the door was propped open. Upstairs bedroom doors were propped open with chairs or walking frames.

The registered manager told us that equipment and utility safety checks had been carried out in the previous 12 months. However, they were unable to confirm if the gas safety check due in January 2018 had been carried out. The electrical wiring was checked in June 2017, but the certificate of compliance was unavailable, because identified faults had not yet been resolved. The registered manager told us, "The electrical certificate will not be issued until issues had been resolved. I believe this may take two to three months to resolve fully."

On 21 February 2018 we brought to the registered manager's attention that the call bell panel in the main hallway did not identify the source of the call when a buzzer sounded. We were told that there was a fault with the system and it would be repaired. On our return on 28 February 2018 we found that there continued to be faults with the call bell system. Two people residing in upstairs bedrooms had their call bells removed as they were faulty and ringing continuously. Two other people did not have access to call bells in their bedroom because there were not enough working call bell handsets for each person living in the service. We

were told that when people were in their bedrooms, that care staff checked on them every thirty minutes, however, our observations did not support this. People were not provided with alternative means of alerting staff when they needed assistance, such as hand bells.

The deputy manager told us about a recent outbreak of diahorreoa and vomiting, where staff were confused about the signs to look for. The management team were unable to identify the cause of the infection. As a result all staff will receive further training on infection control.

The deputy manager and a senior housekeeper were the infection control leads for the service. The senior housekeeper told us that they represented the service at quarterly meeting organised by the local authority infection control team. However, we found that the provider did not always comply with safe infection control practices.

On day one of our inspection we found a blocked toilet, loose and broken toilet seats and faulty handrails to support people to sit on the toilet. The bath hoist was soiled and there was a risk of scalds as the bath did not have a mixer tap. Following the inspection the provider sent us information to show that water temperature checks were being carried out. The water temperature checks were not complete and four bathrooms had no temperatures recorded. The laundry room did not have handwashing facilities. The upstairs sluice room did not have a handwashing sink and staff that used the sluice would be unable to wash their hands. We were informed by a member of care staff that because of the lack of handwashing facilities that they carried soiled commode basins downstairs to the ground floor sluice room. This imposed a risk of spillage of body fluids in communal areas. Several ensuite toilets and shower rooms did not have paper towels, therefore staff would be unable to wash and dry their hands before leaving the person's bedroom. We observed that inadequate barrier nursing was being practiced and there were no appropriate control measures in place to reduce the risk of infections being spread.

We looked at medicine administration records (MAR) and found that medicines had been given consistently and there were no gaps in the MAR charts. Each MAR chart had a photograph of the person for identification purposes and any allergies and special instructions were recorded. Where a person did not receive their medicine a standard code was used to identify the reason, such as when a person was asleep. However, medicines were not always safely managed. Some people were prescribed as required medicine, such as pain relief, and staff had access to protocols to enable them to administer the medicine safely. However, we saw from the weekly audits that these protocols were not always followed and staff did not record as required medicines on the correct paperwork.

All medicines were stored in accordance with legal requirements, such as locked cupboards, medicines trolleys and fridges. There were processes in place for the ordering and supply of people's medicines to ensure they were received in a timely manner. We carried out a random check of individual stock levels to see if they tallied with the amount recorded on the MAR chart. However, we found when medicines were received into the service that the amount received was not recorded and there was no way of knowing if the stock levels were correct.

We brought to the registered manager's attention that they did not have the legal documents necessary for the safe disposal of medicines. The registered manager was unfamiliar with this document. They consulted with their pharmacist and an electronic copy of the document was obtained. However, the document was out of date and applied to the previous provider organisation, South Yorkshire Care Limited. Hayworth Care Limited had not notified their dispensing pharmacy of this change. In addition the return and disposal of medicines, including controlled drugs, was not being carried out safely. We took a random selection of records for the last six months and found that staff did not sign to confirm that unwanted or out of date

medicines were being destroyed or returned and these returns were not signed by the person receiving them.

On 20 February we observed two medicine rounds. One undertaken by the deputy manager for residential residents was performed competently and professionally. We observed a registered nurse administering medicines to nursing residents and saw that they had left one person's supply of medicines on top of the medicine trolley. The medicine trolley was unattended at intervals during this time. Fifteen minutes passed before the registered nurse realised their error. At lunchtime on 28 February we observed that the medicine room was left unlocked and unattended for five minutes. Both of these incidents increased the risk that people could access and take medicines that were not prescribed for them.

Failure to suitably assess risks to the health and safety of people who received care and treatment and to do all that was reasonably practical to reduce such risks was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not always enough staff on duty to care for people's needs in a safe and timely manner. In the open plan conservatory, lounge and dining area there were several people present with only one member of care staff present to supervise them. The staff member was engaged with two people in a table top activity. We observed three people attempt to go through the security door that led from the dining area to the corridor where their bedrooms were located. One of them grabbed the attention of the staff member. The staff member then escorted the person to the toilet, leaving the remaining people unattended in the locked room with no way of summoning help from staff. There was not a call buzzer with their reach.

Our observations were supported by comments from people and relatives. One person referred to the lack of staff and said, "It's usual round here not to have enough staff around." Other people and their relatives shared their experience of poor staffing levels in the service. One person who was dependent on care staff for all their care needs said, "Night staff sometimes cause issues, leaving me, and they can be rushed and abrupt." Another person's relative told us, "Staffing can sometimes be an issue. I know my family member can refuse care when first woken [in the morning], but when I got here today she was in a bit of a state. I rang the bell and they did come and sort her out."

Over the previous six months there had been a high turnover of nursing and care staff and staff retention was poor. We looked at the duty rota for week commencing 19 February 2018. Due to a lack of permanent registered nurses, the service was dependent on registered nurses from an agency to maintain safe staffing levels. People were not cared for at night by registered nurses who were familiar to them or their nursing needs and this could lead to a lack of continuity in their care. Also, some people living with dementia do not respond well to strangers.

We asked members of staff how they would keep people safe from harm. One member of care staff told us, "Only one person tries to escape through the fire door in the main lounge. [Name of person] likes to wander outside. We asked why they did not support the person outside and were told, "Unable to take for a walk as low staff levels."

We found that some people in upstairs bedrooms would be unable to call on staff for assistance as their call bells were placed out of their reach or they did not have one. In addition, we found that staff did not regularly check on people in the upstairs bedrooms and focused on people who were using the communal areas downstairs. When call bells were activated they were not answered in a timely manner.

Failure to employ sufficient numbers of suitably qualified, competent , skilled and experiences staff was a

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

Recruitment procedures were not operated effectively. We saw that suitable references had not always been obtained. When we discussed this with the registered manager they were unaware that a registered nurse had been employed without suitable references. They also found that their interview record was missing from their personnel file. The registered manager shared concerns they had about the staff members' ability, but had not taken any action to address this. The member of staff was appointed to a senior clinical role and was responsible for the professional development and competency assessment of the registered nurses employed at the service.

Failure to establish and operate effective recruitment procedures is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff had access to the safeguarding policy and we saw notices in the staff room on how to raise concerns. Staff we spoke with told us that they had a basic understanding of safeguarding people form harm or abuse. For example, one member of housekeeping staff said, "I would go to the manager or a senior care worker. I would not take it upon myself to deal with it." In addition staff said that they knew the signs to look for that may indicate that a person was being abused. We received comments such as, "Bruising or isolating themselves" and "anxiety and changes in their behaviour." However, staff had not identified or reported the concerns we identified on our inspection, such as the poor provision of call bells and poor infection control practices.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Prior to our inspection we requested and received information from the local authority mental capacity team about the number of current DoLS authorisations granted to people living in the service. On day one of our inspection the deputy manager was unsure how many people living in the service were subject to a DoLS authorisation. We looked at their DoLS authorisation folder and found that they had the correct documents for people who had a DoLS authorisation granted. However, we also found documentation for people who no longer lived at the service or had passed away. The deputy manager informed us that they would archive these records.

Staff did not follow national guidance and best practice initiatives when a person lacked capacity to give their consent to an aspect of care or treatment. For example, we saw where a person lacked capacity to consent to have their photograph taken that a member of nursing staff signed consent on their behalf, rather than record that the person lacked capacity to give their consent and undertake a best interest assessment. In addition, we found that some people had no near relatives or a lasting power of attorney to act on their behalf when making difficult decisions. For example, when a person had to decide where they lived the service did not request an independent advocate to speak out on the person's behalf.

We found that a record of individual food likes and dislikes were maintained by the cook and reviewed every two months. However, people were not always given their preferences. We observed one person, who preferred to eat finger food, was not provided with it and had difficulty eating their lunchtime meal with cutlery. Several people told us that the food was not always to their liking. We heard comments such as, "It's edible," and "it's so so." We spoke with one person who had not eaten their main course. They had been given sausage and chips and said, "I would not normally eat that type of food." Another person said, "The food is ok. If I don't like it I have a couple of chocolate bars."

We spoke with the cook who told us that they had received training suitable for their role and said, "I've done the nutrition distance learning courses." They explained that meals and hot drinks were served at set times, but people were provided with cold drinks throughout the day. People were offered a choice of main course at lunchtime, and we saw that there were alternatives to the main menu such as soup and sandwiches. Where a person had special dietary requirements their needs were met, such as a vegetarian or

pureed diet. The cook told us that special events such as birthdays were celebrated and they baked a birthday cake.

People were provided with adapted crockery to help them eat their meal without food spilling off their plate. When a person had difficulty eating their meal, a member of care staff assisted them. However, at lunchtime we found that some staff presented people with their meal without telling them what it was and people were not offered condiments or sauces.

We noted that food was a standard item on the agenda at resident meetings and people were invited to give their feedback on the quality of the food provided. Four people gave their feedback at a meeting held on 8 December 2018. People made comments such as, "the food is nice", "quite nice" and happy with food but doesn't want a large amount on her plate". The cook did not attend these meetings to receive feedback first hand.

Recently appointed members of care staff told us that they had shadowed another member of care staff for two shifts as part of their induction. One member of staff who had been in post for six weeks confirmed that their induction had now been signed off as completed. However, we had concerns about the quality of training staff had received as it did not provide them with the skills they needed to deliver safe care. For example, staff could not recall the topics they had covered on their induction; fire safety and online moving and handling training.

We found that the induction had not ensured that new staff were provided with suitable mentorship from more experienced staff. For example on 21 February 2018, we found that there were four members of care staff on duty from 7am to 7pm. They were working together; however, two of these staff had only been working at the service for two weeks and none of them for more than six weeks.

We observed that the same care staff did not have the skills to effectively give care to people. Our observations were supported by comments from people who used the service. One person told us, "Half of them [care staff] don't know what they are doing. Some of them can't even make a bed." Staff told us that they did not always have the "tools" to do their job effectively. One staff member said, "We don't have enough cleansing wipes or [name of the product used to clean a person's skin when it is soiled with body fluids]. We have to use soap and a flannel." This put people at risk of damaged and infected skin. A visiting relative shared their observations of care staff and said, "There is a high turnover of staff. The young ones can't hack the job, but they are scared of allegations [made against them]."

We looked at supervision and appraisal records and found that the supervision records did not demonstrate that supervision was supportive or that staff had the skills. For example, one supervision record recorded each topic discussed as "no issues". There was no record of future professional development, training or responsibilities to complete. This demonstrates that staff were not supported to identify their own learning and development needs.

If a person became unwell and required urgent care and treatment in hospital, there was a "grab sheet" that provided hospital staff with important information such as details of the person's family, known allergies and a list of their current medicines. Before a person moves into the service they were assessed by senior staff to ensure that the service could meet all of their care and support needs.

People had access to healthcare professionals, such as their GP and district nurse. However, the service was inconsistent in its approach in accessing professional help in a timely manner. We spoke with one person who was resting on their bed who told us that they felt dizzy. We informed the registered nurse who said that

the person often complained of being dizzy and there was nothing of concern and they did not need to inform the person's GP. The person care file recorded that they had fallen twice four days before our visit. We then spoke with the deputy manager who said that they had discussed the person with their GP and they were now having their blood pressure monitored. We found no evidence in the person's care file that they were having their blood pressure recorded or that the GP had been asked to review them.

People who lived in the service were at significant risk of harm due to the lack of systems in place to identify and report signs of illness. Registered nursing staff had not followed national guidance on identifying the early signs of sepsis. We looked at the daily care logs for one person who had died from sepsis and found that registered nurses did not regularly record their vital signs such as temperature, blood pressure and pulse. These observations would have informed registered nursing staff of the severity of the person's deteriorating health. We saw that this lack of written information was consistent with other people's records. For example, we found several entries recorded a person's day as, "settled".

People were not provided with information and support to assist them to live a healthy lifestyle. We found no evidence that they had access to exercise or were supported to walk in the grounds. We saw that on admission to the service some people were asked about their hobbies and interests, but they were not supported to maintain them. During the three days of our inspection we observed that most people sat in the lounge areas. They were lethargic and slept most of the day in their armchairs. There was no mental or physical stimulation to keep them alert and improve or maintain their overall wellbeing.

There were several notice boards in the main hallway and in the dining room. The majority of notice boards were set about eye level, and would be difficult to read for people of small stature or who are dependent on a wheelchair to mobilise. In addition, most of the information was in small print and there was no alternative easy read format available. People with visual or cognitive problems would have difficulty reading and understanding this information. On day one of our inspection the menu board in the dining room displayed the previous day's menu.

There was a quiet lounge where people could be alone with their relatives if they wished. However, we saw that this was often used for meetings with stakeholders and commissioners of services. People were also able to meet with their relatives in their bedroom.

Requires Improvement

Is the service caring?

Our findings

Twenty-five of the 29 people living in the service on day one of our inspection had some form of dementia and most had difficulty articulating their needs. We observed that care staff did not always speak with people appropriately and help orientate them to their surroundings. We found that care staff did not offer alternative forms of communication, such as picture cards or take time for the person to respond to questions. For example, we observed a member of care staff interact with a person who entered the dining area on their own and was disorientated. The person could not find their bedroom and was asking for food. The staff member did not approach the person to comfort or assist them, but said, "What's up with you my darling? You're not safe by yourself darling in your own room. You can't go to your room yet darling." The person then left the dining room to find their room. The member of staff did not go their assistance.

We observed that nursing and care staff did not always recognise or respond when a person required assistance. One person had swollen red feet and ankles and were sat with them on the floor. They had not been provided with a foot stool to elevate them and relieve the swelling. We brought this to the deputy manager's attention who asked a member of care staff to fetch a pouffe, as there were no available foot stools designed for this purpose. The staff member approached the person, did not use their name, did not explain to the person what they were doing or show any concern for their comfort. We noted that the person was left with their feet hanging over the edge of the pouffe. There was a risk that this would increase pressure on the person's ankles and cause damage to their skin.

People were not always treated with dignity and respect. In the main lounge and dining area we observed that another person with a diagnosed chest infection had slipped down in their armchair and was choking on their phlegm. The person did not have a paper tissue or a receptacle to cough into and was coughing up mucus onto their clothes. This was in full view of other people sitting in this area. Nursing and care staff were in the vicinity but did not respond to their distress or attempt to maintain their dignity. We asked the registered nurse to intervene as the person had difficulty breathing. The person was assisted to sit upright in their chair and handed a tissue. No offer was made to assist the person to move to a quieter area or to change out of their soiled clothes. The registered nurse told us that it would not be long before the person slid down in their chair again.

A visiting healthcare professional shared their concerns about the service. They told us that people were not treated with dignity, the standard of care was poor and the service was not clean. They had raised their concerns with the deputy manager on previous visits, but had not seen any signs of improvement in staff attitudes and behaviours.

Staff did not attempt to engage with people on a level that people understood. We observed staff talk down to people in a childlike manner and raised voice. When morning and afternoon drinks were being served, staff did not give people time to decide what they would like to drink. People were given a cup of whatever staff thought they should drink. We mentioned this to one member of care staff who replied, "That's what they always have."

One person who was planning to return home told us that staff had been very kind to them and added, "I'll miss them when I go home." A relative told us that they were made to feel welcome and said, "It is like a family here. Even the cleaner will come in [to the bedroom] to chat." We looked at the comments that people made at the last residents meeting held on 8 December 2017. Recorded comments included, "everyone looks after me", "they were all good to me" and "just want to go home."

Inadequate

Is the service responsive?

Our findings

We found that people had information on how to make a complaint on their wardrobe door. However, we are unsure how people living with dementia or had visual problems would access this as it was not in an easy read format and the print was small.

The complaints procedure and guidance in the Service User Guide and Statement of Purpose did not provide adequate information for people who lived in the service and their relatives on how to escalate an unresolved complaint to the Local Government Ombudsman or the local authority. Following our inspection we were provided with a revised copy of the Service User Guide on 23 February 2018. We noted that the contact address for Hayworth Care Limited was incorrect and any concerns were to be made to a service that was no longer registered with the provider. We looked at complaints received in the last 12 months and found that complaints were not always resolved in a timely manner. One person's relative had complained about the non-return of a deposit, this had been on-going since May 2017. We noted there was no record in the complaint file that this matter had been resolved.

There was no evidence recorded in care plans that people and their family had been involved in planning their care or that people or their families had been invited to or taken part in regular reviews of their care or that the outcome of reviews had been communicated to them. Overall we found no evidence that the service worked in partnership with people to help them make informed decisions about their care. We noted that there were red, yellow or green dots on bedroom doors. The deputy manager explained that this was to assist care staff to understand the mobility needs of individual people. For example, dependent, partially dependent and independent with mobilising.

It was difficult to follow the care pathway of individual people. The care files lacked organisation and continuity. Daily information about people who lived in the service was recorded in different folders and we found conflicting information. For example, individual daily care logs were kept separate from the care files. One person had one fall recorded on their falls log, but their daily care log identified several falls. Referrals to health professionals were recorded in daily care logs, however, we noted that one person's nutrition and hydration care plans both identified that the person needed to be referred to their GP. We found no record that this had been actioned.

On day two of our inspection we found evidence that people received care that was not supported by national guidance, but was ritualistic and task orientated, such as the use of a daily task allocation sheet, including a bath list and a daily work sheet detailing care staff to attend to a peoples' toilet needs at a set time. Seven days later on day three of our inspection we were shown a revised daily task allocation sheet. This was developed in response to concerns raised with the registered manager on day two of our inspection. However, this was also task orientated rather than person centred. Care staff referred to people in their care as tasks to do. One member of care staff said, "I started at seven and a lot were up, washed and dressed. I have a list of who was done." They also referred to people as "singles and doubles." This related to a person's dependency on either one or two care staff for personal care.

The provider's attempts to recruit an activity coordinator had been unsuccessful. We observed that there was very little mental or social stimulation or activities for people. We spoke with two people sat at a dining room table with pre-school age children's puzzles in front of them. One of them told us, "It's just a kid's game." When we asked them about their hobbies they spoke with enthusiasm about their love of cricket and how they had played for many years. We observed four people being supported by a member of care staff to play with similar puzzles. The puzzles were brightly coloured and people found it difficult to differentiate between them and the brightly coloured table cloths.

Other people we spoke with told us about their previous hobbies and interests and shared that they had now lost interest in them. We did not see staff help people to continue to follow their hobbies. One person told us, "I love to knit and sew at home. I have a knitting machine and do lots of things, but I have no interest here. I am not interested. I used to walk and I had a dog, but I'm not interested now. I just pray that I will be allowed to go home." Another person told us that they would rather not live in the service and said, "I don't go out, because if I do then I wouldn't come back. I'd end up in a tent in Skegness or somewhere, quite happy."

A registered nurse told us that when care staff had time they would spend it with the residents playing with puzzles or reminiscing. A visiting healthcare professional also commented on the lack of social stimulation for people living at the service. We spoke with person they had visited and found that their television was switched on, but was situated behind them and they were unable to watch it.

The Statement of Purpose informed the reader that the service organised outings. However, staff told us that people did not leave the service for days out or visits to the shops and no one was supported to maintain links with the local community.

We found that the lack of social and cognitive stimulation had a negative effect on the well-being of some people who lived at the service. We spoke with one person who was admitted to Cathedral Nursing Home a few months earlier was quiet and withdrawn. They told us that they remained in their bed all day through personal choice and that they never took their meals in the dining room. We noted that their call buzzer was out with their reach. We spoke with the person who told us that staff did not drop in on them very often and they did not know how they would alert staff if they required assistance with anything.

Failure to provide people with person centred care that reflected their needs and preferences was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A consultant led community frailty team visited people in the service who were near the end of their life. A health professional from the frailty team told us that they worked in partnership with the person, their family and GP to enable the person to have a peaceful, dignified and pain free death. However, they found it difficult to engage nursing and senior staff at Cathedral Nursing Home to become involved and work in partnership with them. Nursing staff did not always recognise when a person was near the end of their life and were slow to refer to the frailty team for right support and care for the person. They told us that due to the high turnover of staff, it was difficult to train care staff in essential aspects of care such as caring for a person's mouth when they were no longer able to do so for themselves.

Inadequate

Is the service well-led?

Our findings

We found that the provider did not have effective systems and processes to assess and monitor the quality and safety of the service. Audits were undertaken as part of the provider's governance system. We found when an area for improvement was identified the registered manager had not reviewed action plans to ensure they delegated responsibility and had clear time scales and the registered manager had not monitored action plans to ensure that staff identified to lead on areas were taking appropriate action. Staff were not given feedback from audits. We saw the kitchen audit undertaken in December 2017 had 23 actions for improvement identified, however only three actions had been signed as completed. The mattress audit carried out in December 2017 identified that five people were cared for in bed; therefore their mattresses were not checked. This intentional omission meant that staff had no way of knowing if the condition of the individual mattresses were appropriate for people most at risk of pressure damage. The provider had relied on their registered manager and had failed to complete any checks of their own that the services was being competently managed.

We looked at the action plan completed by the provider for a medicines audit undertaken on 23 January 2018. The action plan stated, "The audit was very messy with silly mistakes being made on a regular basis." The recorded actions stated, "I suggest that the manager has a supervision session on all staff that give out medicines." There was no timescale for this action. There were two further actions, "Staff must fill out on a daily basis, 1. Temperature of the medication rooms and 2. Daily temperature of fridges." When we queried the lack of detail with the registered manager we were provided with a second action plan titled Medication Action Plan Feb 2018. This action plan had 25 actions recorded; however there was no information on who would be responsible for the actions or a realistic timeframe to complete them. The actual audit tool used was not available in the service for the inspection team to look at.

Our observations and feedback from staff confirmed that there was no visible leadership in the service. Care staff told us that they did not know the registered manager and had not spoken with them. However, the registered manager had interviewed care staff for their current posts. Furthermore, they all said that the deputy manager was approachable and a good role model.

People were able to give their feedback on the service at bi-annual resident meetings. We looked at the minutes from the meetings held on 19 May 2017 and 8 December 2017. The registered manager did not attend these meetings and neither did the cook to receive people's feedback on the quality and choice of food provided. The standard agenda items were care, food and activities. We saw that feedback given about the activities people would like had not been actioned. We looked at the minutes of the last staff meeting held on 10 November 2018.The registered manager had not attended this meeting. We saw that key topics discussed focussed on staff knowledge, attitude, behaviour and respect for management. Recently appointed care staff told us that they had not attended any meetings.

Systems to store Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms were not robust. Copies of all active DNACPR forms were kept in the person's care file and a photocopy was stored in a designated

folder for all DNACPR forms. The photocopies were in colour and there was nothing to identify which copy was the original. The Resuscitation Council (UK) guidance clearly recommends that any copies made should only be for audit purposes, should be printed in a different colour and clearly identify that they are not the original to prevent the potential danger of a copy being used to guide clinical decisions when the original may have been cancelled.

Failure to provide systems and processes that assess, monitor and improve the quality of the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014