Acer Healthcare Operations 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**

Summary of findings

Overall summary

About the service
Cedar Court is registered to provide accommodation and personal care for up to 75 people who may have a nursing need, a disability or may be living with dementia. There were 67 people living at the service at the time of our inspection.

People's experience of using this service and what we found

There had been a change in management at the service since the last inspection and the provider had not robust oversight of the quality of care during this transition. There were not always enough staff deployed at the service which left people at risk. Risks associated with people's care was not always being managed in a safe way including the management of medicines and the cleanliness of the service. Incidents and accidents were not always followed up on to avoid the risk of reoccurrence.

Although staff received training and supervision, this was not effective in ensuring good practice within the service. People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests. Pre-assessments of care and care plans did not always have accurate information about people's care and staff did not always understand people's needs. Although people and relatives knew how to complain they did not always feel listened to. Complaints were not always investigated fully.

People did not always have choices around their care delivery and at times were not treated with dignity and respect. Quality assurance was not always effective. Where shortfalls in care had been identified with staff this had not been addressed robustly. The leadership needed to be more effective in ensuring staff were delivering appropriate care. The provider had failed to maintain robust oversight of the service. As a result, the level of care had deteriorated from the last inspection. People did not always have access to health care professionals to support them with their care. The lay out of the service require improvements to support people that had difficulties.

People and relatives told us that staff were at times kind and caring and we did see examples of this. There were activities on offer for people although improvements were needed at the weekend. Relatives and visitors were welcomed as often as they wanted. People enjoyed the meals on offer at the service. People had access nutritious food and drink through the day.

Previous Inspection
The last rating for this service was Good (Report published 18 September 2018.)

Why we inspected
The inspection took place earlier than planned as we had received concerns about the quality of care being provided. We have found evidence that the provider needs to make improvement. Please see the Safe,

Effective, Caring Responsive and Well Led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Cedar Court Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
Our inspection was completed by two inspectors, a specialist nurse 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.

Service and service type
Cedar Court 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 did not have a registered manager. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. However, the manager that was employed at the service had submitted their application to register with the CQC.

Notice of inspection
This inspection was unannounced. We inspected the service on the 22 October 2019.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who work with the service. A PIR was not requested from the provider on this occasion. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We received feedback from four relatives.

During the inspection
We spoke with 10 people who used the service and six relatives. We spoke with the manager and a peripatetic manager. We also spoke with eight members of staff including nurses, care workers, kitchen staff and housekeeping staff. 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 talk with us.

We reviewed a range of records. This included 10 people's care records and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We also spoke with one health care professional and a relative.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong; Preventing and controlling infection; Using medicines safely

- People and their families were not satisfied with the cleanliness of the service. A relative told us, "I have visited and the room [of their family member] is not always clean, there was a lot of dust under the bed and a piece of mushroom from yesterday's lunch under the bed." Another told us, "Recently I've wished I don't want to come here at all because it's been pretty grim."
- People were not always protected from the risks of unsafe care as staff did not adhere to basic infection control measures. A member of staff told us they would leave the laundry to wash their hands in the bathroom rather than use the sink in the laundry room when they had handled soiled washing. The manager told us , "Cleaning is a big issue."
- The service was not appropriately cleaned and there were communal areas that smelled strongly of urine. A person's soiled trousers had been left in the bathroom which people used. Clothing protectors that people were wearing had not been washed appropriately before they were placed on them. A member of staff said, "I can see that it [the cleanliness] has gotten poor." The bathrooms on the top floor were dirty and the toilet remained unflushed through the day despite there being faeces in it.
- Risk associated with people's care was not always managed in a safe way. On one of the floors, tables were placed near the windows leaving a small space for people that required walking aids. We saw one person at risk of falls trying to mobilise in between the tables but were unable to do so. In the communal bathroom on the top floor a toilet frame had been placed in front of the toilet making it inaccessible to people that were able to access the bathroom independently.
- One person had a condition that meant they could become unwell very quickly. They told us, "I have no sensor in here to alert them [staff]. I'd have to press the call bell and that's not always within reach." We saw there was no sensor in place in their room which would reduce the risk of staff not being immediately aware should the person's health deteriorate.
- There were not always food and fluid target amounts recorded to indicate what the expected intake should be. Where food was being recorded there was not always information on what the measurements of food was. For example, where it stated 'On pureed' there was no information of what this meant in terms of the amounts.
- Where people were at risk of developing a pressure sore their care plan did not always have an assessment to manage this. For example, one person was permanently cared for in bed. They had recently had a wound and a wound care plan was in place. However, the skin assessment for them stated that they were at no or low risk of developing a pressure sore.
- There was broken furniture in the communal corridor where people were living with dementia which placed people at risk of injury.
- The stock of medicines were not always managed in a safe way which impacted on whether there was

sufficient medicine for people. One relative informed us that the service had run out of their medicine. They said, "They [staff] called 111. Luckily [the pharmacy] in Cranleigh was open. It was agreed that we could go there and get 10 tablets." Although the person did not miss a dose of their medicine there was a risk that this could have occurred. The nurse staff on duty told us that they had not been trained on the electronic system where they needed to order medicine. The management team were aware of the concerns with the electronic monitoring of medicines counts.

● We checked the counts of the medicines and found that there were discrepancies for homely remedies used for people for mild pain relief. As a result, there was a risk that medicines would not always be available when needed. The peripatetic manager told us that they had not audited the homely remedies. The nurses were also unable to locate the consent forms from the GP to confirm they were able to give homely remedies. This was despite their policy stating that this needed to be in place.

● Medicines were also not disposed of when they were out of date. We found several medicines that had gone past the date to be used by. The manager told us they had identified a number of concerns with the management of medicines however they were still only auditing medicines monthly and no sooner. However the audit of stock of medicine was taking place more regularly. After the inspection a health care professional had been asked by the nursing staff to process repeat prescriptions requests however some of the medicines for people had stopped some months before.

● Accidents and incidents did not always have detailed information recorded on the actions taken to reduce further occurrence. On the falls analysis we asked the manager to complete for us it had been identified that there were people that had fallen and yet there had been no updated falls risk assessment on their care plan. On the accident and incident forms we reviewed there was little detail on what preventative measures had been taken to reduce further occurrence. For example, in relation to people having falls, and where a person had choked.

Failure to provide people's care in a safe way was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were aspects of the management of risks that were adequately managed. For example, one person was at risk of falls and used a walking aid. The care plan states that staff were to support them with their walking frame and to allow the person time to rest if they had been standing for any length of time. We saw this taking place on the day.

● Where people had an air mattress the settings were checked and recorded by staff to ensure that it was correct.

● A person was at risk of having a seizure. There was a risk assessment in place and guidance for staff on what actions they needed to take if the person had a seizure.

● Each person's had a Personal Emergency Evacuation Plan (PEEP) which outlined how the person could be removed or kept safe in the event of an emergency, such as fire or flood and staff were aware of these. There was a service contingency plan so that in the event of an emergency such as a fire or flood people could be evacuated to neighbouring services. All staff had received fire safety training.

● The medicine room was securely locked, and the fridge temperature was checked daily to ensure it was at a safe temperature.

Staffing and recruitment

● People and relatives told us there were not enough staff. Comments included, "I don't think they have enough staff. Particularly at meal times", "There is definitely not enough staff. If I press the call bell I have to wait, and I'm waiting in bed when I want to get up for a shower in the morning" and, "The call bells go on and on. I came here last Wednesday at 11:30am and she was still in bed. Once they knew I was here they were rushing around getting her ready. Her lunch was at 12."

● There were not enough staff effectively deployed to support people when they needed. Staff were not around when people needed them, putting them at risk of harm, such as falls, and not meeting people's preferences, such as when they want to get up in the mornings. One relative told us, "Sometimes she [family member] still being showered at 11am. I think this is because the staff are too busy or have other priorities."
● On the top floor there was only one member of staff sat with people in the dining room. This member of staff was assisting a person to eat. There were people getting up from chairs without their walking aids. Other people living at the service were having to assist the person as there was no other member of staff available.
● Before the inspection the manager had told us they had increased staff levels in September to reduce the number of falls people were having. However, there was no system in place to continuously monitor this. After the inspection we asked the manager to provide us with an analysis of falls that had taken place in the service to include up to the date of the inspection. However, we were only provided with information for September 2019. This identified that there had been 37 falls and that 11 of these had occurred at the weekend. There was no analysis of whether the falls were due to there being a lack of staff deployed where needed.
● Staff told us that, at times, they needed more staff to assist them. One told us, "From January 2019 there are only two cleaners all over the home, sometimes only one. This is not enough so we are not doing it properly." We spoke to the manager about the staff levels. They told us, "We are not understaffed. There are issues around the organisation of the day. For me this home is very task orientated." They had ensured that there was an increase of domiciliary staff including cleaners and laundry staff.

Failure to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Safe recruitment practices were not followed when employing new staff. There was not always a full employment history for staff despite this being a requirement on the application form.
● Where references had been sought they did not always have information on the member of staffs' character or their conduct at work. The provider had not acted on information supplied in references to ensure prospective staff were safe to work with people at risk. One reference had clearly identified that the previous employer would not employ the staff again, but there was no information on the interview notes that the member of staff being asked about this. The manager was not able to advise us of why they were not asked.
● There were however Disclosure and Barring Service (DBS) checks in place and evidence of the identity of all staff files we looked at. DBS checks are carried out to confirm whether prospective new staff had a criminal record or were barred from working with people.

The recruitment procedures to ensure that staff employed were fit and proper were not robust. This is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People told us that they felt safe at the service. One told us, "I feel safe living They have told me I had months to live but I am still going strong." A relative told us, "We feel [person] is safe, I have observed how staff treated him when he got upset and they were very caring."
● Safeguarding incidents were being reported appropriately and investigated by the manager. Staff had received training in safeguarding and were able to tell us what they would do if they suspected abuse.
● One member of staff said, "I have reported safeguarding matters in the past so would be fine in reporting anything else that came up." Another said, "I would report anything to do my line manager. I know I can whistleblow too. I'd speak to you guys or the council too."

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes

Ensuring consent to care and treatment in line with law and guidance

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 to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

- Where decisions were being made for people there was no evidence that their capacity had been assessed for example, one person was being restricted from leaving the service. There had been no capacity assessment in relation to this or DoLS application to the local authority to determine that this was a legal deprivation of their liberty. A member of staff told us about this, "[Person] lacks capacity. We have not been able to do an MCA assessment with her. She can go into the garden but not out into the main entrance or out the front of the house. A DoLS is not place as far as aware." They told us the assessment had not been done because they had not had time.
- Where capacity assessments had taken place, they were not always completed appropriately and had conflicting information. For example, one assessment stated that the person had capacity. Later it stated that the person had an impairment of the brain but did not confirm if they had the ability to retain, understand and weigh up the information. It then stated, "This person lacks capacity to make this specific decision for themselves." Another person had full capacity however in their care plan related to the medicine for their seizures its states that the person during these seizures lacks capacity. The manager told us action was now being taken to address the shortfalls.
- Staff received training around MCA and DoLS however there was a lack of understanding of the principals involved. For example, one person was being given medicine covertly (disguised in drink or food). However, there was no record of any capacity assessment of best interest meeting to indicate why it was agreed that they should have their medicine in this way. Nor had staff realised that giving people medicines covertly meant it should come under DoLS.

As the requirement of MCA and consent to care and treatment was not followed this is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff support: induction, training, skills and experience

● People and relatives were not always confident that all staff were trained effectively to support them, particularly if the staff were not familiar with the person they provided care to. One person said, "There's a lot of agency staff at the moment, and I understand the need for them. But what I don't get is why not allow them time to read the care plans, so they know the people they are looking after?" There was a lack of meaningful information given to agency staff on the needs of people.

● We found during our inspection that staff were not always familiar with the background of people and what care they required. We asked one nurse about the background of one person they were delivering care to and they told us they did not know. They were unable to explain how they needed to be safely moved when providing personal care.

● Staff fed back that a management decision had been made to rota the staff on to different units. They felt that this was not providing continuity of care. One told us, "I disagree with [the manager] rotaring the staff around all the units all the time." Another relative told us that their family member had a particular routine that not all staff were familiar with.

● Although training was provided to staff this was not effective in ensuring that staff understood what they needed to do. During the inspection we found shortfalls in practices around infection control, MCA, medicines and the management of risks. The nursing staff advised us that they had not received training in using syringe drivers and sepsis training. One health care professional told us, "Changes to people on end of life can happen very quickly. I would expect staff to be competent with a syringe driver." Despite us requesting it, we were not provided with the list of clinical training that nurses had received.

● Although there were supervisions taking place this was not effective in ensuring that any shortfalls identified were followed up. Group clinical supervisions were taking place but not as a one to one with the nursing staff that were new to the service and required this support. The supervision policy stated that four supervisions should take place a year with staff and only one of these should be a group supervision. The supervision matrix identified that staff had only had one supervision in 2019.

● Staff fed back that they did not always feel supported with their role and had concerns about the induction for staff. One told us, "We use agency but there is no induction [for them]." Another told us, "I do not feel supported in my role from the management team."

As staff were not appropriately trained and supervised in their role this is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● There was a mixed response from people and their relatives when asked if people had access to health care professionals when needed. One person told us, "There are occasions when I have felt under the weather and the night staff noticed and told the day staff who called a doctor for me." One relative said, "They didn't call in health care professionals when she [their family member] took a dip [decline in health] while I was away" Another said, "Oral care has been diabolical here. I got a mobile dentist in last week. Her [their family member] gums are an issue."

● The manager told us that on one occasion the GP ran out of time and did not see two people on their list. The manager had concerns that nursing staff were not prioritising the right people for the GP to see. As a result, one relative told us that as their family member had not seen the GP they rang the surgery themselves to organise a prescription for their loved one.

● A health care professional contacted us prior to the inspection to raise concerns about the clinical staff's lack of confidence around identifying particular health care conditions. After the inspection another health care professional contacted us to raise their concerns about the clinical competencies of the nursing staff. They told us they had been asked to conduct a medical procedure on a person that had been required a month before. The health care professional told us that nursing staff should have been competent to perform this themselves.
● We did however see care records showed that people had regular annual eye checks and regular involvement of the chiropodist.
● Detailed pre-assessments were not always taking place prior to people using the service. This meant that the service could not be certain that they were able to meet people's needs.
● One person was admitted for respite care however there was a lack of information on their medical background and their current diagnosis. The pre-admission assessment stated in relation to 'Delirium', "Recent episode on admission now resolved." There was no additional information on this. It states that the person had confusion and memory difficulties but no explanation around what caused this.
● The second assessment we looked at contained more detail but still lacked information on the persons background, likes, dislikes and interests. There was also conflicting information on the assessment. Under communication it stated, "Does not communicate her needs." However, under the, "Pain" section it states that they can communicate when in pain.

As there was a lack of detailed assessments of people's needs before they delivered care and people were not always supported with their health care needs this is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● Improvements were required to the environment to support those people living with dementia. Although memory boxes were placed outside their rooms these were not always being used. There were not always names or picture aids on people's bedrooms doors to help orientate them to their room.
● There were people that had a visual impairment. There were no observed aids or adaptations to support people with this.
● There were people that were happy with the layout of the service. One person told us, "It's nice here. I have a lovely view of the garden."
● The corridors were wide to allow easy access for people that were wheelchair users. There were outside areas that we saw people accessing during the day.
● Special beds and pressure relieving mattresses were in place for those who needed them.
● Each room had an ensuite and people were able to have personal effects including furniture in their bedrooms.

Failure to plan care and treatment around people's needs was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People told us that they enjoyed the food at the service. Comments included, "You can have a vegetarian option. I enjoy the food" and, "The food is very good. I select what I would like, and staff come round to ask me about my choices. If there is something else I would like to have then I can have that." A relative told us, "They've [staff] been excellent, since she moved in she has been eating better."
● The chef was provided the information about people's dietary needs including whether meals needed to be modified, for example pureed, and those that had allergies. The chef told us, "We go through the care plans to see what people want. I meet with people and their families and ask if they are happy with the

variety. Food is at times the only thing left for them to enjoy."

● We observed that throughout the day people were offered snacks in between meals. During lunch people were offered a selection of hot meals and alternatives offered if people wanted something different. However, we noted that for people that were on restrictive diets they were not routinely offered two choices of meals. For example, those people on a pureed meal were not offered two choices. The chef told us that they could offer the person an alternative if they did not like what had been offered to them.

● People had access to drinks through the day and there were drinks stations at the service for people to help themselves if they wanted. We saw people accessing these.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- There were mixed responses from people about the caring nature of staff. One person said, "They [staff] are always kind with me. They treat me nice and talk to me like a friend." Another said, "Care staff are acting in a positive and caring way as best they can." However, a third person said, "I don't feel like they spend much time getting to know me." Another said, "Some of them it seems like a job to them and they don't seem interested in you personally."
- There were times during the inspection where staff did not always act in a caring way towards people. During lunch in one dining room staff placed meals in front people without saying what the food was. We overheard people asking out loud what the meal was.
- During lunch we saw staff talking amongst themselves rather than chat to people that were having their meal. The atmosphere during lunch in one dining room was quiet and there was no engagement from staff.
- Relatives fed back that their family members clothes were not presented in a nice way. One told us, "I have found him dressed in the same outfit for few days in a row. There was a time when he had no socks washed for a week." Another told us, "It was important to [person] to look immaculate and he would not be happy to know that he is not always wearing proper clothes and looking smart."
- On one of the floors there was loud maintenance work being undertaken in a room opposite where two people were in bed. The noise lasted until at least 11.50am and we heard one person commenting that there was a lot of noise. We found it difficult speaking with people due to the noise. No consideration had been given to the impact this could have, for example being frightened by the noise, or feeling isolated as they did not understand what was going on.

Supporting people to express their views and be involved in making decisions about their care;

- People fed back that they did not always have choices around their care delivery. When asked if they were able to get up when they wanted, one person said, "It's not about when it suits me. I think staff have certain times they need to see people and they get on with it." Another said, "People feel that staff don't get to know them or talk to them. I think this is down to the amount of staff that have left." A relative told us, "I've never been involved in reviews."
- Another person told us that staff did not always support them to choose the clothes they wanted. They told us, "I do not know what colour clothes I am wearing any more as I cannot see." We asked if staff told them the colours and they replied that they did not. A relative said, "The agency staff are on the move all the time, so they don't have time to read the care plans. They can't form relationships with people because of it."

● People were not always asked what drink they would like. One member of staff was heard asking another member of staff if they should give a person a cup of tea. The other member of staff suggested orange juice instead. Neither member of staff asked the person what they wanted.
● People's choices on whether they wanted a male of female carer was not always adhered to. One person told us, "There are definitely not enough female carers here at the moment. The men are lovely, but that doesn't mean that I don't want a female to wash me."

Respecting and promoting people's privacy, dignity and independence
● People did not always feel that they were treated with respect by staff. One person told us that they asked a member of staff if they could top up their water. They said the member of staff responded unhappily saying to them, "Someone else should have done it."
● People's clothes and bedding were not separated into lights and darks when it was being washed. We saw that as a result white clothes and sheets were turned grey. The manager told us, "There are an awful lot of clothes for all the residents. They have to also be hung up and taken back to people's rooms." However, we found that this was not always happening. The clothes in the laundry room were disorganised and some clothes were stained. One person told us, "My the laundry is horrific. Everything goes missing, even though my name is on my clothes."
● The glasses that some people were offered drinks in were stained and old which was undignified for them.
● We saw piles of people's lost clothes that had been left in a room at the service and referred to as a, "Jumble sale" by the manager for people to come and claim. This included people's vests and socks. The clothes were not laid out nicely and people were expected to search through this to look for clothes that may be theirs. This was undignified. One relative told us, "There's a lack of attention to laundry. I've heard there's a mountain of clothes unclaimed."

As people were not always able to make choices around their care and were not always treated in a caring and respectful way this is a breach of 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We did see times where staff acted in a caring way towards people. During lunch in one of the dining rooms a member of staff entered the room and started chatting to people asking them if they were enjoying their lunch and telling them what activities were taking place that day.
● When one member of staff was chatting to a person they placed their arm around them. The person had a smile on their face and people were engaged with the member of staff. We overheard a member of staff enter a person's rooms and say, "Are you okay, can I get anything for you?" The person replied, "No thank you."
● When personal care was being provided this was done behind closed doors. Staff knocked on people's doors and waiting for them to respond before they walked in. One person said, "Staff ask for my permission and knock on the door.''
● Family and friends were welcomed to the service whenever they wanted.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs. People's needs were not always met.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; End of life care and support; Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● Care plans contained some information on the likes and interests that people had but this was not detailed. There was information missing on people's preferred routines and their life histories. The peripatetic manager told us, "The care plans do present some challenges. We have identified some needs. We are identifying and putting measures in place. We are looking at six care plan audits every month. We are working through this."
● There was not always sufficient and up to date guidance in the care plans around the specific needs of people. This meant that there was a risk that staff would not deliver the most appropriate care particularly as there was high levels of agency staff used. For example, in one care plan it stated that the person ate independently. However, the person was unable to eat or drink without staff supporting them with this. There was guidance lacking on how the person needed to be supported.
● Another person's 'Mobility Care Plan' stated that the person was able to walk with a walking frame, however the nurse on duty told us that they were no longer able to stand. The person was being cared for on their own bed which was pushed against the wall. The nurse was unable to tell us how staff were able to safely move and handle the person when providing personal care. This was despite this being raised as a concern in the providers audit in September 2019. The care plan also stated that the person was able to use a call bell if they needed assistance. The nurse advised that they were no longer able to do this.
● One person's blood sugar level needed to be checked three times a day. The care plan detailed what the healthy blood sugar ranges should be. We saw several occasions where the blood sugar levels were not being recorded. We also observed that, where the recordings indicated an 'unsafe' level, there was not always evidence of what actions were taken as a result.
● End of life care was not being planned around people's wishes. There was insufficient evidence that discussions took place with people including people's spirituality, religion, what family they wanted around them and where they wanted to be at the end of their life.
● Where preferences had been identified, these were not always supported. One person that was being cared for in bed and was nearing the end of their life, liked listening to classical music. This had been recorded in their care plan, but there was no music playing in the person's room.

● Care plans did not always detail how best to communicate with the person. There were care plans that stated how staff should maintain eye contact with the person and to speak clearly. However, there were other people with disabilities where guidance was lacking. For example, there were people that were visually impaired. There was no evidence that this had been considered when providing them with information on their care.
● Relatives did not always feel consulted or communicated with in relation to their family members care. One relative said, "You have to ask if you want information. You would think after 56 years of marriage I would be entitled to know things. Another said, "The staff don't keep me updated, it's a problem."

Failure to plan care and treatment around people's needs was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● People and relatives told us that they did not feel their complaints were listened to or acted upon. One person said, "I have raised concerns to the manager, but they are never responded to." A relative said, "We feel listened by some staff, we have talked to (manager) about few things, but they have not been resolved so far. We do not know what has been done."
● Complaints and concerns were reviewed by the manager and peripatetic manager. They were not always investigated fully, and people and their relatives were not always satisfied with the response. For example, a relative had raised a complaint that their family member had not had their meals served to them. The response provided to them did not detail what investigation had taken place or what preventative measures were being put in place to ensure that this did not happen again.
● Complaints were not always recorded with notes of what actions had been taken. For example, one relative told us their family members shoes had gone missing and had submitted a complaint. We checked the complaints records and there was no information in there relating to this. The relative told us, "When they were given back they were ruined as they had been put in the wash."

As actions were not taken as a result of complaints this is a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them;
● People told us that they enjoyed the activities at the service. One person told us, "We are provided with a list of activities that take place. They always ask if I want to take part in the activities." Another told us, "The activities they offer do not interest me but that is my choice. If I wanted something, then I would ask. I have enough to keep me busy and my family visit me a lot."
● There were activities taking place including visits from a 'Pat' dog, sing along sessions, a social club, a breakfast club, entertainers and trips out. During the day we observed a 'Days gone by' discussion with the activities coordinator and people which people were really engaged with.
● Where people were cared for their room activity staff visited them to undertake one to ones to reduce the risk of social isolation.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care;

● People and relatives had mixed opinions about the management at the service. One person said, "[The manager] is always ready to help and will always speak when she goes past, and she will always use my name." Another said, "I've met [the manager]. She's a very lovely girl." Other comments included, "The manager isn't approachable due to her accessibility and when you do get to see or speak to her she never seems like she is happy or wants to talk to people" and "I know who she [the manager] is but I don't really get to talk to her except from when I first moved in."
● Staff also had varying opinions of how they felt the service was managed. One told us, "I believe the manager is professional. She knows what she is doing." Another told us, "I feel very supported by the manager." A third told us, "From the last inspection we had everything was working well and going well. We got on top of everything. We had a massive staff drop and it's now quite difficult."
● The manager had been working at the service for the past six months and acknowledged that this had been a difficult process for them. We found that improvements could have been made relating to how accessible the manager was. The manager told us, "People always expect to have access to the manager, but issues can be brought to the nurse. I may say, "Have you spoken to the nurse in charge?" There was not sufficient acknowledgement that this was people's home and that managers should be accessible to them where needed.
● Where shortfalls had been identified by the management team these had not always been addressed. For example, the manager told us that they were aware of the poor standards of cleanliness of the service, however sufficient action had not been taken to address this. We also found on the medicine audit undertaken in September 2019 where some shortfalls were identified with gaps on the MAR charts. It was noted on the audit that the nurse was frequently interrupted when giving medicines. There was no record of how this had been addressed.
● In a provider audit in August 2019 the poor cleanliness had been identified and the action was for the service to have an, "Industrial deep clean." The deadline for this to be arranged was the 20 August 2019. This had not been done.
● Records at the service were not always accurate and did not always reflect the accurate needs of people. In one person's care plan it stated that the person was not on any medicine however, we saw a note from the GP that the person was on anti-biotics for an infection. The food and fluid charts in place for people were not always being completed when needed. One member of staff said, "Sometimes we get to the end of day and there are things that have not been finished or completed such as paperwork." Actions were being

taken to address this.
● The providers own policies were not being followed effectively." . The infection control policy stated that, "The manager is responsible for monitoring practices and ensuring that audits are carried out periodically. Any action required will be formulated into an action plan." The recruitment policy stated, "All application forms must be completed in full with no gaps." We found that this had not always been followed.
● The cleaning audits that were completed did not reflect what we found at the inspection. These audits were a tick list that indicated that rooms, bathrooms, shower head and the kitchen had been cleaned.
● When we fed back the shortfalls to the manager during and at the end of the inspection they told us, "Nothing came as a surprise." They told us that when they first came to the work at the service they had identified the shortfalls.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff did not always feel engaged with or involved in the running of the service. One member of staff said, "Things that worked before have been changed and there have been no reasons given why."
● We were told by the manager that due to the rural area of service, transport was put on to pick up staff from Cranleigh. The manager said, "There was an issue around transport. The mini bus was doing several pickups just within Cranleigh. We introduced a single point of pick up. I had to translate that to staff and they were not consulted with as they would have said no. I do try my hardest to include staff." However, staff fed back that they were not happy that they were not consulted.
● People and relatives' feedback was not always valued. Prior to the inspection people and their families contacted us about the concerns they had over the quality of the care being provided, including the cleanliness and laundry at the service. The manager told us that they had been approached by families. The peripatetic manager said, "They [relatives] have raised issues over the quality of care but in a non-specific way. No examples have ever been given." However, during the inspection, we found concerns with the laundry and the cleanliness. One person said, "It's all slowly getting worse and no one explains to people the reasons why things are so bad, no communication at all."
● Although residents and relatives meetings took place these were not always effective in ensuring that care was improved from feedback. One relative said of the meetings, "They're [management] too defensive and not open about the issues." Another said, "Sometimes my wife doesn't come out with socks on due to the laundry issues. Someone suggested a net bag in the residents meeting which they said they would take on board." We did not see that this had been actioned. The minutes of the meetings showed that people and their relatives were also raising concerns about the cleanliness at the service.
● We reviewed the minutes of the latest staff meeting where the concerns were again raised about the cleanliness. There was criticism raised by the management team of the staff competencies in their role. Where staff attempted to identify where they believed some of the shortfalls may have come from this was not listened to by the management team. The minutes stated, "Staff were quick to point the finger at the agency staff." This statement in the minutes came across as dismissive and not respecting the views of the substantive staff.

As quality checks and leadership was not always robust this is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After the inspection the provider sent us a detailed action plan that indicated that steps were going to be taken to address the concerns identified as a result of the inspection. This included a deep clean of the service, the recruitment of additional staff to clean the service, summary care plans for agency staff and additional clinical support and training for nursing staff. They advised that they consider not admitting further people to the service until they were satisfied the shortfalls had been addressed. We will check on

these improvements at the next inspection.

● 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. Whilst on the inspection we identified incidents of safeguarding that had not been notified to the CQC.
● One person had been punched in the face by a person and again this had not been reported to the CQC. The manager told us, "He [person] hit a person. I reported it SCC but not to CQC." They told us they did not realise that this was a requirement.

As notifiable incidents were not always been sent in to the CQC this is a breach of regulation 18 of the (Registration) Regulations 2009.

Working in partnership with others; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● Where incidents and accidents had occurred, we noted from the records that families were contacted.
● The provider and manager worked with external organisations that regularly supported the service. One member of staff said, "We've got excellent links with the church. We have different schools that come in and do things for us. Surrey university are doing a concert for us soon. We had the scouts who brought their burners and they made tea for people. Another school are sending their students who are doing Duke of Edinburgh visits. We had five today who want to be doctors." We saw these visitors present in the service who were interacting well with people.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	The provider had not sent in notifications to the CQC where required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The provider had not always planned care and treatment around people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The provider had not ensured that people were always treated with dignity and respect

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The provider had not ensured that the requirement of MCA and consent to care and treatment was being followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had not ensured that people's care was being provided in a safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had not ensured that complaints were fully investigated and responded to.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that quality checks and leadership was always robust.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that there were sufficient numbers of suitably qualified, competent, skilled and experienced staff.