Cleveland Lodge Limited

Cleveland Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Cleveland Lodge is a care home which provides accommodation and personal care for up to 18 older people who are living with dementia. At the time of our inspection 16 people were living at Cleveland Lodge.

This inspection took place on 1 February 2017 and was unannounced. We returned on 10 February 2017 to complete the inspection.

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

At the last comprehensive inspection in November 2014 we identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because people were not protected against the risks associated with the unsafe use and management of medicines because of inaccurate records of medicines held in the service. In response to that inspection we issued a requirement notice. The provider developed an action plan to address the shortfalls, which they submitted to us following the inspection.

At this inspection we found the provider had taken action to address the issues highlighted in the action plan. However, we still found some unsafe medicines management due to lack of recording. For example people's photographs were attached to their MAR sheets to aid identification, however we found medicine allergies and people's date of birth were not always recorded.

There were sufficient staff to meet people's basic care needs. However staff were not always deployed in a way that kept people safe. People had limited opportunities to take part in activities or hobbies and interests of their choice. There was lack of social interaction. People didn't have opportunities to go out into the community, which meant people were at risk of social isolation. Relatives told us they had been concerned about the staffing levels for some time.

The service did not always follow the requirements of the Mental Capacity Act when people lacked the capacity to give consent to care and treatment. We found that where people were not able to consent to living at Cleveland Lodge associated mental capacity assessments to consent to care and treatment at Cleveland Lodge, were not completed.

Staff did not receive sufficient appraisal and supervision to support them to carry out their work, as effectively as possible.

People were supported to have sufficient food and drink and to maintain a balanced diet. However we observed and relatives commented that there was a lack of variety in food.

We found there weren't any systems in place to monitor people's experience of care. There was also no evidence to show people's involvement in their care reviews.

People received care and support from staff who had got to know them well. The relationships between staff and people receiving support demonstrated dignity and respect at all times.

Relatives spoke very highly of the care their family member was receiving. Comments from relatives included "You get excellent treatment here. You can't improve on excellence", "Couldn't fault the carers", "Carers had got to know [person]. They [person] trust the carers now. They [carers] are really good with [person]" and "The carers go beyond what is needed. Nothing is too hard".

Staff told us they knew the processes they needed to follow should they suspect abuse had taken place. Staff told us they received training in the safeguarding of vulnerable adults and training records confirmed this.

Risks to people's safety had been assessed and plans were in place to minimise these risks. This included risks in relation to falls, malnutrition and developing pressure ulceration.

Staff told us they had the training and skills they needed to meet the needs of the people they were supporting. New staff were supported to complete an induction programme when they started working at the home and were able to shadow more experienced members of staff before working independently.

People were supported to maintain good health and had access to healthcare and other services to meet their needs.

The provider had some quality monitoring systems in place. Accidents and incidents were investigated and discussed with staff to minimise the risks or reoccurrence. The management operated an on call system to enable staff to seek advice in an emergency.

Staff told us they felt supported and the registered manager was accessible to talk to. The registered manager covered shifts at times, including night shifts. The registered manager told us this gave them an opportunity to observe staff practice, while working alongside them.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 for which we are taking action and will report on this when it is concluded. One of these breaches was repeated from the last inspection as sufficient action had not been taken to address the shortfalls. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

This service was not always safe

There were sufficient staff to meet people's basic care needs. However staff were not always deployed in a way that kept people safe.

Medicines were not always managed safely.

Staff recognised the signs of potential abuse and knew what to do when safeguarding concerns were raised.

Is the service effective?

Requires Improvement

The service was not effective in some areas.

The service did not always follow the requirements of the Mental Capacity Act when people lacked the capacity to give consent to care and treatment.

Staff did not receive appraisal and supervision to support them to carry out their work, as effectively as possible.

People had access to food and drink throughout the day and were provided with support to eat and drink where necessary.

Is the service caring?

Good

This service was caring.

People were treated with kindness and compassion in their day to day care and support.

Staff knew the people they were caring for including their preferences for how they would like to receive care.

Staff had developed good relationships with people and their families.

Is the service responsive?

Requires Improvement

This service was not always responsive.

People's care plans did not always contain the most up to date information to enable staff to be responsive to people's needs. People were not involved in their care reviews.

Relatives said they were able to speak with staff or the Managers, if they had any concerns or a complaint. They were confident their concerns would be listened to and appropriate action taken.

People were not encouraged and supported to follow their interests or to go out in the community.

Is the service well-led?

Requires Improvement

This service was not always well-led

There were some quality assurance systems in place, however there were no systems in place to monitor people's experience of care.

The service had made some community links.

Staff told us they felt supported by the registered manager. The registered manager worked alongside staff and covered some shifts to ensure best practice.

Cleveland Lodge

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 1 and 10 February 2017 and was unannounced. The inspection was completed by one Inspector.

At the last comprehensive inspection in November 2014 we identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because people were not protected against the risks associated with unsafe use and management of medicines because of inaccurate records of medicines held in the service. In response to that inspection we issued a requirement notice. The provider developed an action plan to address the shortfalls, which they submitted to us following the inspection.

Before the inspection we reviewed the information we held about the service. We read the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we held about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

People were not able to tell us what they thought about living at Cleveland Lodge. We therefore used a number of different methods to help us understand the experiences of people who use the service. This included talking with six visiting relatives about their views on the quality of the care and support being provided. During the two days of our inspection we observed the interactions between people using the service and staff. We used the Short Observational Framework for
Inspection (SOFI). We used this to help us see what people's experiences were. The tool allowed us to spend time watching what was going on in the service and helped us to record whether they had positive experiences.

We looked at documents that related to people's care and support and the management of the service. We

reviewed a range of records, which included four care and support plans, daily records, staff training records, staff duty rosters, personnel files, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices.

We spoke with the registered manager, the owner, three care staff, housekeeping staff, the chef, and the activities coordinator. We received feedback from one health and social care professional who worked alongside the service.

Requires Improvement

Is the service safe?

Our findings

At the last comprehensive inspection in November 2014 we identified that the service was not meeting Regulation 13 Management of medicines of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because people who use the service and others were not protected against the risks associated with unsafe use and management of medicines because of inaccurate records of medicines held in the service. Following that inspection we issued a requirement notice. The provider developed an action plan to address the shortfalls, which they submitted to us following the inspection.

During this inspection we found some improvement had been made, however we still found some unsafe medicines management due to lack of recording. We looked at the current medicines administration records in the home. The pharmacy provided printed Medicine Administration Records (MAR) for staff to complete when they administered residents their medicines. Medicine Administration Records (MAR) were found to be mostly up to date with all signatures in place, however we found gaps for one person, which had not been identified. We raised this with the staff member at the time, who could not explain the gaps and said the registered manager checked the MARs for gaps. A staff member we spoke with confirmed that MARs would only be signed once they had witnessed the person taking their medicines. This meant there were opportunities for confusion as staff were not clear on the medicines administered.

We saw hand written entries on the MAR chars for medicines changes which lacked detail on the directions and quantities carried forward . This also wasn't checked and signed by a second trained member of staff before the first use, which would be seen as good practice to ensure the handwritten entry was correct.

Medicines were stored securely. Medicines were stored in accordance with their storage requirements and storage temperatures were checked and recorded daily in line with this. People's photographs were attached to their MAR sheets to aid identification, however we found medicine allergies and people's date of birth were not always recorded. Processes were in place to ensure medicines that were no longer required were disposed of safely.

We observed medicines being administered on the lunchtime medicine round in a safe and respectful way. The staff member stayed with the person to ensure they had swallowed their medicines and drinks safely. Where people were not ready to take their medicine the staff member respected this and returned when they were ready. We found some people were being given their medicines covertly (without their knowledge, mixed with food and/or drink).

Where people required medicines as and when necessary (PRN) this was always done with advice from the GP as to when to administer it. We observed the staff member asking people if they were in pain and if they wanted pain relief. The staff member recorded on the person's MAR chart if they had administered the pain relief or if the person had declined. Staff told us night staff were not medicines trained, which meant the competent senior day staff member had to stay on until the evening medicines round was completed. If a person needed any PRN medicines during the night, for example pain relief, there would not be a competent medicines trained staff member to administer the required medicines. This could potentially cause people

discomfort and distress.

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

There were sufficient staff to meet people's basic care needs. However, staff were not always deployed in a way that kept people safe. Relatives told us they had been concerned about the staffing levels, especially in the afternoon. Staff were not visible as they were providing personal care in people's bedrooms. Relatives said there had been occasions where a person's safety had been at risk and they could not find a member of staff to intervene. We observed this during our inspection. Some people started walking with a purpose in the afternoon and became active. One person was stacking a chair on top of a table, where another person was sat at. The chair was starting to tumble towards the person and we had to intervene. Later the same person was trying to lift the table where another person was having a hot drink. Again we had to intervene to prevent injury to the other person. We looked at the person's care record and saw there were no strategies in place to support this person's behaviour. The person could have benefitted from some kind of interaction with staff to divert their attention. We also observed a person pulling at someone's clothes who was sat in a chair. Other than some relatives visiting, there was no interaction with people, other than offering a drink. This placed people at risk of potential harm as staff were not present or available to manage the situation.

Staff told us there weren't always sufficient staff to meet people's needs. Some staff felt that at times care was rushed. They said that whilst people always received the care required sometimes they had to wait as they were busy supporting other people. They felt this occurred because sometimes there was not always staff available to cover staff absences. A visiting health care professional told us there was a high turnover of staff and due to this staff roles changed a lot, which meant people were not receiving continuity in their care.

Most relatives we spoke with said they felt their family member was safe living at Cleveland Lodge, however some felt they had to come in most days to ensure their family member was safe. Comments included "[Person] is safe because I come and keep an eye", and "I don't always feel that [person] is safe when I leave".

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

Risks to people's safety had been assessed and plans were in place to minimise these risks. This included risks in relation to falls, malnutrition and developing pressure ulceration. There was information in people's care plans which provided staff with guidance on how to reduce these risks. We found for a new admission who had a specialist condition, that staff had not received the necessary training to care for this person. Community nurses had to provide urgent training to staff to ensure this person's safety. A health care professional said "This person should not have been admitted to the home. They had no idea what was involved". Since the admission, the health care professional had seen an improvement and the person's condition had been managed well. However there were concerns for the person's safety initially and the community nurses had to monitor the situation very closely.

Some people's care plans stated they had to be checked two hourly during the night. We found that staff recorded they had checked all the people to be monitored two hourly at the same time for example records showed people were checked at 9pm, 11pm and 1am. This was the same for all people on two hourly checks, which meant this was not a true reflection of the time the person was checked.

Occasionally people became upset, anxious or emotional. We saw that there wasn't always consistent guidance for staff on what to do for example when a person became aggressive or resistive to care. We saw some guidance was recorded in some people's care records, but not in others. This meant staff were not always consistent in their approach in supporting people who had behaviours that could challenge others.

Staff told us they knew the processes they needed to follow should they suspect abuse had taken place. Staff told us they received training in the safeguarding of vulnerable adults and training records confirmed this. Staff said they would report abuse if they were concerned and were confident the manager would act on their concerns. Staff were aware of the option to take their concerns to agencies outside of the service if they felt actions to deal with their concerns were not being taken.

We saw safe recruitment and selection processes were in place. We looked at the files for five of the staff employed and found that appropriate checks were undertaken before they commenced work. The staff files included evidence that pre-employment checks had been made including written references, satisfactory Disclosure and Barring Service clearance (DBS) and evidence of their identity had been obtained. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

Measures were in place to maintain standards of cleanliness and hygiene in the home. For example, there was a cleaning schedule which housekeeping staff followed to ensure all areas of the home were appropriately cleaned. We found bedrooms and communal areas were clean and tidy. The service had adequate stocks of personal protective equipment such as gloves and aprons for staff to use to prevent the spread of infection. A health care professional told the service didn't manage people's laundry safely and that people did not have their own individually named towels and flannels. This meant that after a wash, towels and flannels were distributed throughout the home, increasing the risk of cross contamination. We were also told that the towels were put on a boil wash, which made the towels very hard and could damage an older person's fragile skin. A relative told us there had been problems with the management of people's laundry, but the service now had two washing machines, which had resolve some of the issues.

The service had appropriate arrangements in place for managing emergencies. There was a contingency plan in place which contained information about what to do should an unexpected event occur. We saw people did not have a personal emergency evacuation plan in place, which meant the emergency services would not have access to information regarding people's mobility and cognitive functioning if an evacuation was needed. For example, a flood or loss of utilities. There were arrangements in place for staff to be able to seek out of hours management support should they require it.

Requires Improvement

Is the service effective?

Our findings

We looked at how the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). 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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found that where people were not able to consent to living at Cleveland Lodge, associated mental capacity assessments to consent to care and treatment at Cleveland Lodge, were not completed. Where people lacked capacity to make specific decisions around their personal hygiene or nutrition, mental capacity assessments were in place, however it was not decision specific and it did not evidence who was involved in the discussions to come to a best interest decision. We observed staff supporting people in making some day to day decisions and choices, for example where to sit. Staff told us they involved people in making choices as much as possible. They would give people a visual choice to assist in making a decision, for example what clothing they wanted to wear.

The registered manager had identified a number of people who they believed were being deprived of their liberty. They had made DoLS applications to the supervisory body and were awaiting assessment.

Some people had given others lasting power of attorney (LPA) in relation to either their finances or their care and welfare. This gave them the power to take decisions on behalf of the person if they lacked mental capacity. The service had not consistently obtained details of LPAs where people had them and was not always recorded in people's care records. The service did not ask to see a copy of the registered LPA, which meant relatives, could be making decisions on behalf of people where they did not have the legal powers to do so.

Relatives spoke positively about staff and told us they were skilled to meet their needs. Comments included: "They all know what they are doing" and "Carers are good at judging what a particular person needs each day".

Staff told us they had the training and skills they needed to meet the needs of the people they were supporting. New staff were supported to complete an induction programme when they started working at the home and were able to shadow more experienced members of staff before working independently. Training undertaken by staff included safeguarding of vulnerable adults, fire safety, infection control and moving & handling.

The staff we spoke with told us they had not received regular supervision (one-to-one meeting with their

manager) or an appraisal. A senior member of staff told us they had not received supervision the past two years they had been employed by the service. For another staff member we saw the last time they had an appraisal was in 2014. These meetings would also be an opportunity to discuss any difficulties or concerns staff had. We raised this with the registered manager who told us they had only recently been in post as manager and supervision and appraisals will now be booked more frequently. This meant staff were not receiving appropriate on-going or periodic supervision for their role to make sure competence was maintained

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

People were supported to have sufficient food and drink and to maintain a balanced diet. We saw people had a choice of toast, cereals or porridge for breakfast and the main meal at lunchtime with a pudding, with a lighter tea time meal. Some relatives commented that it would be nice to have a wider variety of food, for example sometimes offer people the choice of a cooked breakfast. Some relatives also commented that they usually took their family member's favourite foods to ensure they got it. One relative said "You get what you are given at lunchtime" and another said "I've asked for an egg for breakfast for [family member] before, but was told it would not be fair to other residents".

People were not involved in creating the menu but the chef told us people's likes, dislikes and preferences were known and recorded in people's care plans. The chef said that if people did not like what was on the menu, they would be given an alternative. There was a set three weekly menu and a staff member told us curry was always on the menu; however people did not particularly enjoy it. We asked the chef if people could have more of a choice at lunchtime. They responded that people would not be able to choose due to their dementia. We raised this with the registered manager who told us the chefs had not completed any dementia awareness or mental capacity training. A health care professional also raised concerns that the chef had not had any training in diabetes as some people at the home were diabetic. The professional had to advice the chef on diabetic diets at the time of the person's admission.

We recommend that both chefs complete the provider's mandatory training and not just training specific to their role.

Care files contained a section dedicated to eating and drinking which recorded nutritional status and dietary needs such as the need for fortified or pureed food, swallowing difficulties and assistance required to eat and drink. We observed that the majority of people were having a soft or pureed diet. We checked three nutritional care plans and saw it was recorded the person needed pureed food and thickened drinks due to swallowing difficulties. We saw an associated mental capacity assessment for this decision, but it was not recorded which professionals were consulted and how they came to this decision for the person to have a soft diet. For example it wasn't clear if a referral had been made to speech and language therapy for the people who were on a soft or pureed diet. One relative told us their family member didn't have any dentures and was therefore on a soft diet. We could not see in this person's care plan if any other alternatives had been explored, for example a visit from the dentist.

The kitchen was clean and tidy and had appropriate colour coded equipment and utensils to ensure that food was prepared in line with food safety guidance. The kitchen had been awarded a Food and Hygiene five star rating by the food standards agency. The food standards agency is responsible for protecting public health in relation to food in England, Wales and Northern Ireland.

Food and fluids were monitored for some people at risk of malnutrition. We saw that people's weight was

monitored and recorded monthly and where people's weight had changed, remedial action was taken, a referral to the appropriate health professional was made and a management support plan put into place.

People were supported to maintain good health and had access to healthcare and other services to meet their needs. There were records of treatments relating to chiropody, eye care and district nurse visits in people's records. A GP visited the home on a weekly basis and more frequently as requested by staff in response to people's medical needs.

The building was easily accessible for people living with dementia. There were coloured walls, pictorial signage on bathroom and toilet areas and clearly named room doors to help people find their way around independently. People had signs up by their bedroom door, with pictures of items significant to them which helped people find their way to their bedroom without assistance. We saw that around the home there were different objects for reminiscence.

Good

Is the service caring?

Our findings

People received care and support from staff who had got to know them well. The relationships between staff and people receiving support demonstrated dignity and respect at all times. Relatives spoke very highly of the care their family member was receiving. Comments from relatives included "You get excellent treatment here. You can't improve on excellence", "Couldn't fault the carers", "Carers had got to know [person]. They [person] trust the carers now. They [carers] are really good with [person]" and "The carers go beyond what is needed. Nothing is too hard".

The registered manager told us that some relatives found it difficult to come to terms with facing some of the changes in people due to living with dementia. The service had arranged a coffee morning for relatives with a dementia specialist to increase relatives' understanding, but was also an opportunity for relatives to share information and their feelings. Speaking with relatives they found this very useful.

We observed people were treated with dignity and their privacy was respected. Staff knocked on people's bedroom doors before entering and all personal care was provided behind closed doors. We saw people's preferences for male or female carers were recorded in their care plans and people could choose when they get up and when they went to bed. A relatives said "Yes, definitely treated with dignity and respect".

People were given the information and explanations they need as tasks were undertaken by staff. We observed staff assisting one person to reposition in bed, explaining what was happening "You will just feel my hands slightly. We are going to slide you up the bed now". This meant the person was informed about the tasks the staff were undertaking and ensured they did not become anxious when being repositioned.

Staff knew people's individual communication skills, abilities and preferences. For example staff told us when a certain person put their hand in front of their mouth when eating, it meant they didn't want any more or when they started crying, they might need the toilet. Another person would communicate pain and discomfort through their facial expression or body language; they would become distressed and cry quietly. Staff told us they knew that other than offering pain relief, the person normally calms down with a biscuit and cup of tea.

We found there was no systems in place to make sure people were able to say how they felt about the caring approach of the service. People's views were not sought through care reviews or annual surveys. Relatives told us they normally received an annual survey, but didn't receive one in 2016.

Relatives told us they could visit any time they like. They said carers were good at judging people's mood in the morning. One relative told us the carers recognised the sign when their family member was in a "bad" mood and would be resistive to care. The carers knew to leave the person and go back later.

People's bedrooms were personalised. People were surrounded by items within their rooms that were important and meaningful to them. This included such items as books, ornaments and photographs. People had access to two communal lounge areas within the home and had limited access to the garden. The

owner told us this was mostly used in the summer.

People and their relatives were given support when making decisions about their preferences for end of life care. We saw people did not have end of life or advanced care plans in place. The registered manager told us people were not able to have that discussion and many relatives did not feel ready to talk about it. Where necessary, people and staff were supported by palliative care specialists. Services and equipment were provided as and when needed. During our inspection a person's health had deteriorated and the service was communicating with the GP, relatives and community nurses. The owner told us as the weekend was approaching, they were organising "Just in case" medicines to ensure these would be available when the person needed it.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed prior to them moving into the service and care and support plans developed using this information. We looked at the care files of four of the people living at the home. Care plans had detailed information about various areas of people's care, for example mobility, pressure areas, personal hygiene and nutrition. We saw that associated risk assessments were completed. We found that people's life stories were not consistently recorded, for example which jobs people used to do, important events in their lives and memories about their childhood. Not all care plans were person centred, with some having a more task orientated approach, for example "Need full assistance with personal care". People's daily routines were not clearly recorded, for example what time people liked to get up, how they wanted to spend their day and when they wanted to go to bed.

During the two days of our inspection we found people were not involved in any activities. We spoke to a staff member who was employed as the activities coordinator, from 10am – 12pm four days a week. This person also provided personal care some days from 7am – 10am. The staff member told us they usually took steps to involve people in activities such as arts and crafts and playing games. However due to staff shortness they had not been able to support people with activities. They also told us their role was due to change, so there would not be an activities person. Relatives told us the service never took people out and it was their responsibility if they wanted their family member to go out more. This meant that people, whose family were not able to take them out, did not go out into the community. One relative said "They don't take people out as they can only take two or three at a time and the manager thinks it's not fair to other residents" and another said "There isn't enough interaction for people". The owner told us they had bought a mini-bus and was hoping to start taking some people to appointments; however they would need staff to be able accompanying them.

A health and social care professional told us the home prided themselves in being specialists in caring for people living with dementia. However, due to staff not being able to sit down with people, people did not get the social stimulation they needed. Some people would benefit from interaction from staff in the afternoon as this was the period they started being active. A staff member said "I know of at least a couple of people who could do with some activities in the afternoon". We observed people were left in their chairs for long periods of time with no interaction from staff, only with the television on. There were books and other reminiscence objects around the home, but staff did not have time to make use of this with people. For example the owner told us people could use "fiddle muffs" which could benefit people for sensory stimulation, but we did not see anyone using these during our inspection. The lack of interaction could put people at risk of social isolation and this also evidenced that a person centred approach was not taken when considering a person's emotional well-being

People's care plans were reviewed by a senior member of staff once a month, however this was mainly tick boxes with a summary of how the person had been that month. Some relatives told us they were involved in an annual care review and we saw some evidence of care reviews when a social care professional was involved. Relatives told us staff kept them informed of any changes in their family member's health.

Some care plans we looked at were dated 2013 with no updates recorded and no evidence of people's involvement in their care review. Care plans had not been updated regularly, which meant it did not show a clear reflection of the person's up to date care needs. We found staff to be knowledgeable about person's needs and they told us they were constantly in communication, especially during handover. A handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored.

Where people were at risk of weight loss or malnutrition, people were assessed using the Malnutrition Universal Screening Tool (MUST) and people's weight was monitored monthly. We saw waterlow [tool used to assess people's potential to develop pressure sores] risk assessments were in place, but found that these were also not consistently reviewed. For example for one person a review of the assessment had not taken place since March 2014 despite being assessed at very high risk. This meant that necessary preventative measures might not have been put in place to prevent skin breakdown and could increase the risk to people's skin integrity.

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

Relatives told us when there were activities, people seemed to really enjoy it, for example a musician visited at times, singing wartime songs or playing the guitar. One relative said "[Person] was very unsettled, until the man came in to play the guitar". There was also a person who visited to do exercises with people once a month. Relatives said the service usually makes a "fuss" when it is a big event, such as Christmas or Easter.

Relatives told us they felt confident that if they had a concern or complaint, that it would be dealt with appropriately. One relative said they once had a complaint about the quality of care during a visit, which they had made a verbal complaint. They said the issue was resolved immediately. A health and social care professional told us when they've had to raise concerns with the registered manager or owner; they generally found them to be responsive and acted on their concerns.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post who was responsible for the day to day running of the service. The manager had only been registered since the 2 December 2016, but had been working alongside the service for many years. We found the registered manager was familiar with people's care and support needs. When we discussed people's needs, the registered manager showed good knowledge of the people using the service. The registered manager was supported by the owner in the day to day running of the service.

The registered manager told us their main challenge had been recruiting and retaining staff. Cleveland Lodge is located in a remote village with limited access to public transport, which was difficult for staff who could not drive, unless they lived locally. The service did not use agency staff, but had access to bank staff for covering absences. Speaking with staff they told us absences were covered between the existing staff group, which meant they had to work extra shifts at times to cover. We discussed the concerns raised about staffing levels with the registered manager, who stated they had identified that staffing was becoming an issue. Part of the home was closed and therefore staffing numbers had been reduced when the provider reduced the number of beds. However, we observed during our inspection that people's dependency levels due to their dementia were not taken into account when staff numbers were reduced. The registered manager told us they were reviewing this.

Staff told us they felt supported and the registered manager was accessible to talk to. The registered manager covered shifts at times, including night shifts. The registered manager told us this gave them an opportunity to observe staff practice, while working alongside them. The registered manager spoke positively about the staff team and told us it was a lovely staff team to work with. They said relatives had fed back to them about how welcoming staff were. Relatives were always singing their praises.

Some relatives told us they had known the manager before they became registered and felt they had not always been approachable. Comments included "X [manager] is much more approachable now" and "X [manager] comes in most days. You can raise concerns, but X [manager] doesn't always follow it through". Some relatives also told us they thought finances had an implication on the quality of the service people received, for example the quality and variety in food choices as well as the lack of social interaction.

The registered manager and owner told us they were continuously looking at improving the service. For example they were currently looking at replacing all beds to low level beds, which would be beneficial to people at risk of falling out bed. They were also planning to replace the flooring in the communal lounges and dining area, so people would be able to differentiate between the different rooms.

We found there weren't any systems in place to monitor people's experience of care. Relatives received a questionnaire annually; however no surveys were distributed during 2016. This meant the service was not encouraging people and relatives for their feedback on the quality of the service. We generally saw a lack of involving people, for example no evidence of involvement in care reviews or what activities people would like to be involved in. The staff had a good understanding and knowledge of supporting people living with dementia, however from our observations this knowledge was not always used effectively.

The service had made some community links, for example with the GP surgery, local churches, community mental health and community nursing team. The registered manager told us they stayed up to date with new legislations and guidance through using Skills for care and they would be looking at attending registered manager's meetings as well as Wiltshire care partnership. Skills for care provide practical tools and support for providers to recruit, develop and lead their staff. The registered manager currently did not receive any one-to-one meetings for their own professional development as a suitable person was not available.

Staff members' training was monitored by the registered manager to make sure their knowledge and skills were up to date. There was a training record of when staff had received training and when it was due to be refreshed. Staff told us they received the correct training to assist them to carry out their roles. We found that some staff who were not employed in a caring capacity, did not complete the training for staff working with people in a care setting.

Procedures for recording and reporting accidents and incidents were in place and these were reviewed monthly by the registered manager and a trend analysis completed to identify if there were any reoccurring themes. The registered manager told us they would for example look at medicines the person was prescribed, timings of falls and location of the incident or accident.

People benefited from staff who understood and were confident about using the whistleblowing procedure. Whistleblowing was the term used when staff alert the service or outside agencies where there were concerned about other staff's care practice. All the staff confirmed they understood how they could share concerns about the care people received from other staff. Staff knew and understood what was expected of their roles and responsibilities.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The service did not make every reasonable effort to provide opportunities to involve people in making decisions about their care and treatment, and support them to do this.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Records of medicines management were not always completed correctly. The audit of medicines management had not identified any shortfalls.

The enforcement action we took:

Notice of Proposal to impose a condition on your registration for the regulated activity accommodation for persons who require nursing or personal care

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they were employed to perform. A sufficient number of staff were not deployed in order to meet the needs of people using the service and keep them safe at all times.

The enforcement action we took:

Notice of Proposal to impose a condition on your registration for the regulated activity accommodation for persons who require nursing or personal care.