Four Seasons 2000 Limited

York Court

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?	**Inadequate**
Is the service well-led?	**Inadequate**

Overall summary

This inspection took place on 19 and 20 January 2015 and was unannounced. At our last inspection in July 2014 the service was not meeting the regulations looked at. These related to the care and welfare of people using services, meeting people's nutritional needs, cooperating with other providers and staffing levels within the home.

York Court provides accommodation, nursing and personal care for up to 59 older people over three floors. There were 53 people using the service when we visited.

At the time of our inspection the manager was in the process of registering with the CQC. Following our inspection the manager left the organisation and an interim manager has been managing the service since.. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

Since our last inspection there had been three different managers at the service. There had been a high number of safeguarding alerts during this period which had caused concern to the Care Quality Commission (CQC)

Summary of findings

and the local authority safeguarding team. As a result, the local authority had imposed an embargo on the home and had held regular meetings with managerial staff to monitor the quality and safety of the service.

Safeguarding concerns were not always reported as required. We were alerted to five allegations of abuse which had not been reported to CQC.

Risks were not always managed appropriately and people and their relatives were not always involved in decisions regarding risks. We saw two examples where risks to people had not been fully assessed and sufficient preventative measures had not been put in place.

Staff told us they had received first aid training every three years and were able to explain how they would respond to a medical emergency. We were told that nursing staff were expected to know who did not want to be resuscitated in the event of a medical emergency. However, one nurse was unable to tell us this.

Safe practices for administering and storing medicines were followed. Nurses had completed medicines administration training and appropriate auditing procedures were in place to ensure medicines were stored and administered appropriately.

Adequate numbers of staff were safely recruited into the service. However, staff training and development was not suitably monitored.

People's behaviour that challenged was not consistently managed in a way that maintained their safety and protected their rights. We were made aware by watching the practise of the staff of two people whose behaviours were not being managed according to expert advice.

People were generally supported to maintain good health by having access to healthcare services and people were supported to eat and drink sufficient quantities to maintain a balanced diet.

Staff were trained in the Mental Capacity Act 2005 (MCA) which is a law to protect people who do not have the capacity to make decisions for themselves. Staff were also trained in the Deprivation of Liberty Safeguards (DoLs) which are part of the MCA and exist to make sure that people's freedom is not inappropriately restricted where they lack the capacity to make certain decisions. Staff demonstrated a good understanding of their responsibilities.

People and their relatives were not consistently involved in making decisions about their care. Relatives complained about not being kept informed about people's care.

People's privacy and dignity was not being consistently respected. Four relatives and one healthcare professional expressed their concerns to us.

There was inadequate provision of activities. People, relatives and staff confirmed that there were not enough meaningful activities to engage people. We observed people having very little to do for most of our inspection.

Complaints, and accident and incident records were incomplete and some were not recorded, reported or investigated.

There was an absence of effective quality monitoring and auditing.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 relating to care and welfare, safeguarding, respecting and involving people, quality monitoring and supporting staff. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Safeguarding concerns were not always reported and investigated as required.

People were not always protected from harm as risks were not always managed appropriately and not all nursing staff were aware of people's individual needs in the event of a medical emergency.

Medicines were managed safely.

There were adequate numbers of staff to meet people's needs and the required checks were carried out to ensure staff were suitable to work with people using the service.

Is the service effective?

Inadequate

The service was not effective. Staff training, supervision and appraisals were not monitored to ensure they took place to provide effective support for staff to carry out their roles.

Behaviour that challenged the service was not always managed in a way that maintained people's safety and protected their rights.

People were supported to eat and drink in sufficient quantities and maintain a balanced diet. People were generally supported to have access to healthcare services.

Staff were trained in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Staff demonstrated a good understanding of their responsibilities.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring. People and their relatives were not always involved in making decisions about their care.

We saw some caring interactions between staff and people using the service, but also saw some uncaring interactions. People's privacy and dignity was not always consistently maintained.

Is the service responsive?

Inadequate

The service was not responsive. There was a lack of meaningful activities in the home.

People's concerns and complaints were not being consistently investigated and resolved in good time.

There was little evidence of involvement from people and their relatives in the planning of care. Care records and risk assessments were written in a formulaic way with very little written detail about changes in people's needs.

Summary of findings

Is the service well-led?

Inadequate

The service was not well led. The leadership and management arrangements were ineffective and did not protect people from the risk of unsafe or inappropriate care

There was very little evidence of any form of quality monitoring or auditing to ensure that shortfalls were identified and improvements made.

York Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

The inspection team consisted of one inspector, a specialist advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspection was unannounced.

Before our inspection we reviewed information we held about the provider, including notifications of incidents affecting people's safety and wellbeing. We spoke with the local safeguarding team manager before our inspection and 10 other health and social care professionals after our inspection who provided support to people who used service.

We met and spoke with 11 people who used the service and 30 relatives and friends of people using the service so they could give their views about the home.

Some people could not tell us what they thought about the service because they could not communicate with us verbally. We therefore used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help us to understand the experience of people who could not talk with us.

We spoke with14 staff including the chef, two nurses, care assistants, the manager, the deputy manager and the regional manager. Following our inspection we were informed that the manager had left the service and that an interim manager had been appointed. We spoke with the interim manager following our inspection to follow up on information provided by relatives and to obtain further information.

We looked at five people's care plans and other documents relating to their care including risk assessments and medicines records. We looked at other records held at the home including some accident and incident records, staff records safeguarding and complaints records.

Inadequate

Is the service safe?

Our findings

People using the service told us they felt safe. However, relatives had mixed views about people's safety. Of the 30 relatives and friends we spoke with, 13 gave reasons why they did not feel their family member was always safe. Some comments related to the length of time taken for staff to answer call bells and some relatives were concerned that staff did not provide their relative with enough attention.

At our previous inspection we found that some information in care records was not correct. During this inspection we found that there were still inconsistencies in care records. For example, two out of the five care records we viewed did not include risk assessments for all identified risks such as behaviour that challenged the service. There was no guidance for staff about how to minimise the risks to the individuals or others and no information about the triggers for such behaviours and how to respond to these. We saw evidence of an incident that had occurred that had been the subject of a safeguarding investigation involving the individuals concerned. Although we saw some evidence that preventative measures had been considered, the people involved were not adequately monitored and staff told us that there was a possibility that a similar incident would reoccur as the risks had not been adequately managed.

Arrangements for responding to medical emergencies did not protect people from unsafe or inappropriate care. Staff received first aid training every three years and were able to accurately explain how they would respond to a medical emergency. The deputy manager told us that nurses were aware of who did not require resuscitation and said this was an essential part of their role. However, one of the nurses we spoke with was unable to tell us who did not require resuscitation in the event of an emergency. A member of staff told us that these details used to be relayed as a part of the staff handover between shifts but said this practice had now ceased and staff were unclear why. A relative told us that staff had mistakenly thought their family member did not require resuscitation and we saw correspondence between this relative and staff that confirmed this.

The above issues meant that risks were not always managed appropriately to ensure that people were kept safe. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safeguarding concerns were not always reported as required. The manager alerted us to one safeguarding incident which had not been reported to the Care Quality Commission (CQC) in line with their obligations. Following our inspection we spoke with four relatives who alerted us to other allegations of abuse which had been reported to the management team. We spoke with the interim manager about these allegations. They agreed that three allegations had not been reported or acted on and that one allegation had not been reported to the CQC, but was reported to and investigated by the local safeguarding team which we confirmed. All allegations were reported to the local authority for investigation after our inspection by both the service and the CQC.

We were told by a relative and healthcare professional that they had seen bruises on one person which had not been recorded, reported or investigated. We looked at this person's care records and accident and incident records that were shown to us. We did not see any evidence of these concerns being investigated. We spoke with the interim manager about these allegations. They confirmed that no investigations had been conducted into these incidents of bruising and could not explain why. A second healthcare professional told us they had seen bruises on other residents which had not been recorded, reported or investigated in any way. They told us they had reminded staff that they were supposed to do this and had been assured that it would be done. They were not aware whether their advice had been followed.

Therefore we could not be assured that the provider was taking appropriate action to protect people from the risk of abuse. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our last inspection in July 2014 the Care Quality Commission (CQC) had received notification of eleven safeguarding alerts. As a result of this high number of alerts, the local safeguarding team had been working closely with other health and social care professionals to investigate the concerns and to implement an

Inadequate

Is the service safe?

improvement plan. CQC had been in regular contact with the local safeguarding team to monitor the safety and wellbeing of people using the service. As a result of these safeguarding concerns the provider agreed to a voluntary suspension on admissions to the home which was in place at the time of our inspection.

Staff told us they understood how to recognise potential abuse and explained how they should report their concerns. Staff members gave examples of the possible signs of abuse and correctly explained the procedure to follow if they had any concerns. Staff told us they had completed safeguarding adults training within the last two years, but there were no records available to evidence this.

Medicines were managed safely. Medicines were delivered on a monthly basis for named individuals by the local pharmacy and stored safely in a locked cupboard. Copies of prescription forms were kept with the medicines administration record (MAR) charts to enable staff to check that the correct medicines were given to people.

We checked the MAR charts for two people for the previous day and for the day of our inspection. We saw these had been fully completed. Daily records were completed by the person administering medicines and we saw these were countersigned by a second person. We counted the medicines for two people and saw that this tallied with the records kept.

We spoke with a nurse who was responsible for administering medicines. They told us they carried out daily and monthly checks. These included a counting medicines and checking supplies, expiry dates and storage, including checks to ensure medicines were stored at safe temperatures.

Nursing staff told us they had completed medicines administration training within the last year and this included a test of their competency however, there were no records available to evidence this. When we spoke to nursing staff, they were knowledgeable about how to correctly store and administer medicines.

At our previous inspection we found there were not enough staff to meet people's needs. During this inspection the majority of people who used the service and their relatives told us staffing levels were adequate. Most people told us that whilst staffing levels had been a problem in the past, improvements had been made in recent months. Their comments included "Staffing seems to be increased" and "I think there are enough [staff] around." Staff members themselves told us improvements had been made to staffing numbers and they felt there were enough of them on duty to meet people's needs. However, eight relatives said that there were still some issues with staffing levels. Comments included, "Sometimes there are not enough staff," and "They seem to be in a rush. It seems relentless."

The manager told us they had worked to improve the staffing ratio for the service. She/he told us that monthly dependency assessments were conducted to understand each person's needs and measure this against the numbers of staff required using an electronic dependency tool which calculated staffing numbers. We saw records of monthly dependency assessments on people's files and the electronic record of required staffing numbers. Records indicated that the number of staff scheduled to work during the week of our inspection exceeded the numbers required. We saw that staffing levels on the days of our unannounced inspection matched the number of staff scheduled to work on the staff rota. From our observations there were enough staff to meet people's needs.

We looked at six staff files and saw there was a process for recruiting staff that ensured all required checks were carried out before someone was employed to ensure they were suitable to work with people using the service. These included appropriate written references and proof of identity and criminal record checks.

Inadequate

Is the service effective?

Our findings

People using the service and their relatives told us staff had the necessary skills and knowledge to look after people. One person commented, "They're very helpful." A relative told us, "They do know how to do their jobs." Despite these positive comments, we found that the service was not operating effectively to ensure that people's needs were met.

Staff told us they had completed mandatory training in areas such as safeguarding adults, emergency procedures training, medicines administration and moving and handling. Although staff demonstrated a good level of knowledge in some of these areas, we observed two examples of poor moving and handling techniques on the first day of our inspection. Both people were helped into different positions without the use of hoists, as would have been appropriate and without involving the person so they could assist with the process. Therefore this training had not effectively equipped staff with the skills and knowledge to meet people's individual needs. The management team were unable to provide documentary evidence that this or any other training had taken place. They could not provide any evidence about how they monitored staff training to ensure that it was up to date and that the training effectively supported staff in their roles.

We did not see evidence that staff appraisals and supervisions had taken place within timeframes set by the service. Some staff told us they received supervision from their line manager every two months. The manager told us staff were supposed to receive supervision every two months, but added that some staff supervisions may have been late. We asked the interim manager for evidence of staff supervisions for two people after our inspection as we were told by the deputy manager that they could not access records on the day of our inspection. We found that one staff member had never had supervision with their line manager despite working for the service for over a year and another member of staff had not received supervision for over 10 months. Therefore some staff did not have an opportunity to discuss their performance or training and development needs to ensure they were able to effectively carry out their roles.

The manager told us that staff were supposed to receive annual appraisals and that most staff had received these. Some staff told us they had received an annual appraisal. However, the manager could not provide any evidence of annual appraisals during our inspection. We requested this information after our inspection, but the new interim manager was unable to find evidence of staff appraisals.

The above issues demonstrate that staff were not adequately supported to carry out their roles. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Behaviour that challenged the service was not always managed in a way that maintained people's safety and protected their rights. We saw some instances where staff responded to people's behaviour calmly and quickly and these interventions prevented an escalation of tensions. However, we also saw that some people's behaviour was not being responded to in accordance with professional advice. For example, we observed one staff member speaking to a person with a raised voice. This startled the person and upset them. When we looked at this person's care record we saw they had been visited by a dementia specialist four days earlier who had noted among other matters that this person was sensitive to loud noises. We were also told by a relative and healthcare professional that specific incidents of one person's behaviour that challenged had not been reported or responded to in any way. We looked at this person's care records and did not see any evidence of behaviour monitoring. The interim manager could not explain if or why specific incidents had been unreported. Another healthcare professional told us they had also noticed that behaviour charts were often not filled in for people who required these to be completed so that their needs could be effectively assessed and met to protect them and others from harm.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were generally supported to maintain good health and had access to appropriate healthcare services. We saw evidence of people being seen by healthcare professionals in the care plans we viewed. These included speech and language therapists, physiotherapists, dentists, opticians and dietitians where required. However, of the 30 relatives we spoke with, seven complained about access to healthcare which included access to physiotherapists and

Is the service effective?

hearing aid specialists. The interim manager agreed to investigate these concerns relayed. We spoke with 10 health and social care professionals who worked with staff at York Court who told us that staff contacted them for healthcare advice when required to meet people's needs.

At our previous inspection we found that people's nutritional needs were not always met. During this inspection we found that improvements had been made and that people were supported to eat and drink sufficient quantities and maintain a balanced diet. People and their relatives made generally positive comments about the quality of food provided such as, "The food is adequate," "It's ok" and "The chef is very good." People's care records included information about their dietary requirements and appropriate advice had been obtained from their GP where required. Staff demonstrated a good knowledge of people's nutritional needs. We saw evidence in care records of people's weight being monitored where required and other recorded details including whether they were on a special diet.

The chef told us they obtained feedback from people about the type of food they liked to eat and tried to accommodate people's wishes. Where people did not like the food on offer, alternatives were available. We observed the lunchtime period using the Short Observational Framework for Inspection (SOFI). We saw people were provided with their meals quickly and assistance was provided where required at their own pace.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). We found that the service had policies and procedures in place that ensured staff had guidance if they needed to apply for a DoLS authorisation to restrict a person's liberty in their best interests. Senior staff told us they had been trained to understand when an application should be made and had attended training within the last year. At the time of our inspection several applications had been made for a DoLS authorisation and these had been made in accordance with the law to ensure that people's rights were protected.

Staff had received Mental Capacity Act 2005 (MCA) training and were able to demonstrate that they understood the issues surrounding consent and how they would support people who lacked the capacity to make specific decisions. We saw records of mental capacity assessments in people's files for specific decisions that they were unable to make independently. These met the requirements of the MCA.

Requires Improvement

Is the service caring?

Our findings

People told us they were involved in decisions about their care. Comments included “They do what I say” and “They do things the way I want.” However, relatives gave mixed feedback about their level of involvement in people’s care. Of the 30 people we spoke with, 11 people complained about the lack of communication from staff about their family member’s care. Relatives gave specific examples of situations where they had not been informed about changes in their family member’s condition and many were concerned about not being informed or involved in their care where it would have been appropriate for this to happen. Comments included “I am worried about not being kept in the loop”, “Staff have not explained the deterioration of my [family member’s] condition” and “communication is a problem”.

We saw some evidence in care plans that people were involved in making decisions about their care, but this was inconsistent. Care plans were written from the person’s perspective with examples about the type of care they wanted in some instances. We saw one care plan that included extensive comments from the person’s relative. However, when we spoke with the relative, they told us they had insisted on having their comments included in their family member’s care record and had not been invited to do so. We saw another care record which did not show evidence of family involvement. When we spoke with this person’s relative, they told us they did not feel their views had been taken into account.

During our observations, we saw that staff behaviour was sometimes uncaring and not respectful of people using the service. For example, we observed staff members speaking with one another in raised voices across people in communal rooms and we observed a staff member cut across the pathway of a resident, almost colliding with them and startling them.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed some positive interactions between staff and people living at York Court. For example, we observed friendly and caring interactions and overheard light hearted conversations taking place throughout the day on subjects such as television programmes.

People told us they were treated in a caring way by staff. Comments included, "Staff are fine. They care", “Staff are alright, they are caring” and another person said “The carers are nice.” However, relatives gave mixed feedback about the staff. We spoke with 19 relatives specifically about the staff. The majority of relatives said that staff were caring and did their best to support people, but some there were issues which included poor communication and lack of leadership. Comments included, “A lot of the care staff are very devoted, but communication is a problem”, “Staff are caring, on the whole, but they lack leadership” and “There’s a lot of staff, but no accountability.”

Staff demonstrated an understanding of people’s life histories. They were able to tell us about the important people in the lives of people at the service and where they had previously lived. Staff knew how to respond to people's needs in a way that promoted their individual preferences and choices. Most care plans recorded people's likes and dislikes and included individual details such as their preferred diet as well as the level of support needs they required. However, we saw one example of a care record which did not include details of the person’s preferences or habits. We spoke with this person’s relative who told us this had been a significant problem and they had left detailed instructions with staff to try and rectify this. We saw copies of these instructions displayed in the person’s room, but they were not included in the person’s care record.

People told us, “They respect me” and another person said, “They respect my privacy.” We observed staff knocking on people’s doors before they entered and people confirmed that staff did this routinely. Staff members gave us examples of how they maintained people’s privacy and dignity when providing personal care and in their general interactions with people. However, we received four complaints from relatives about staff failures to promote people’s privacy and dignity. Three relatives complained that people were not taken to the toilet or otherwise provided with personal care when needed. We also observed that there were no curtains in the communal dining area on the ground floor during our inspection. A fourth relative complained to us about this and a member

Requires Improvement

Is the service caring?

of staff stated that members of the public could be seen looking inside the building. We spoke with the interim manager following our inspection who confirmed that curtains had been put up to address this.

Inadequate

Is the service responsive?

Our findings

At our previous inspection we found that there was a lack of activity provision to meet people's individual needs. During this inspection we found that the provider had not made improvements in this area. People complained about a lack of activities and some people complained that the activities were not to their liking. Comments included "I am too old for these activities" and "they are very childish". We observed two activity sessions on different floors of the building. These were a quiz and an exercise session. We spoke with people after the sessions and they told us they enjoyed them. Comments included "These [quizzes] are always well attended" and "I enjoy keeping fit, but what am I going to do for the rest of the day?"

We received 14 complaints from relatives, about a lack of adequate activities. Comments included "There are some activities, but not enough", "[my family member] seems to be only watching telly. What does [my family member] do all day?" and "There's sometimes stuff to do, but it is minimal. The TV will be on, but nobody will be watching."

Activities sessions lasted for approximately one hour and one session was scheduled to take place on each floor of the building every day. For the majority of our time at York Court we observed people sitting in communal areas with very little to do, often falling asleep in their chairs.

Relatives gave positive feedback about the activities coordinator, but everyone we spoke with said this person needed more help. Comments included "She should be helped" and "The activities coordinator is good, but there's only one of her." All of the staff we spoke with confirmed there was an issue with the level of activity provision at York Court.

Care records provided very little detail about people's likes and dislikes in relation to activities. We saw some information recorded about people's level of social interaction, but we did not see objectives for people in relation to their participation in activities or maintenance of hobbies. It was therefore not possible to determine if people were participating in activities that were meaningful to them or what their social and leisure needs were.

There was inconsistency in the level of detail in care records. Care plans were in the form of pre-printed booklets which covered different topics including continence, communication and psychological needs among others. Each section included a written risk assessment on the same topic. Overall, we found care records and risk assessments to be written in a formulaic way with very little written detail about changes in people's needs. Care records included pre admission assessments which covered people's physical and psychological needs. Pre admission assessments were generally not detailed and contained limited information relating to the individual. Care plans had been reviewed within the last six months and some included personalised relating to people's likes and dislikes and included individual details such as their preferred diet as well as the level of support needs they required. We saw one example of a care record which did not contain personalised information relating to the individual and this person's relative complained to us about this. Another care plan we saw contained detailed information about the support needs required, but this had been written by the person's relative and not by staff.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's concerns and complaints were not consistently investigated and responded to in good time. People and their relatives told us they knew how to make a complaint and some relatives told us they had complained to the manager about various matters. Seven relatives told us they had made specific complaints and these had not been responded to. Comments included "I have not heard anything [about my complaint]", "the result of my complaint was not given" and one person told us they had not had a resolution of their complaint despite saying, "We have asked many times".

Copies of the complaints policy were available in the service. The manager told us this was available on request and we saw a copy of this displayed in the building. Records showed that action had been taken to address some complaints that had been made. However, we did not see records relating to the complaints made by the seven relatives who told us they had not received a response. We spoke with the interim manager about this after our inspection. They told us they did not know why these complaints had not been handled and could not provide evidence to demonstrate they had been dealt with appropriately.

Inadequate

Is the service responsive?

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The leadership and management arrangements were ineffective and did not protect people from the risk of unsafe or inappropriate care. We found many examples of underreporting and a lack of recording in relation to safeguarding, complaints and incidents which meant that the provider could not be assured that issues were appropriately addressed.

In addition, there was an absence of effective quality monitoring and auditing to ensure that any shortfalls were identified and addressed to ensure people were kept safe and their needs met. We were shown evidence of medicine audits but staff were unable to show evidence of any other forms of auditing. We asked the manager and subsequent interim manager for further evidence of quality monitoring or auditing. They were unable to provide evidence of any form of quality monitoring or audits. We found that many of the shortfalls identified during our inspection had not been identified by the provider and therefore were not being addressed.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our last inspection there had been three managers at York Court. The third manager was in the process of registering with the CQC, but left two weeks after our inspection. People, their relatives and other healthcare professionals told us instability in the management team had a negative impact on the quality of care. Most people also complained about poor communication in the service. Comments included "[Managerial turnover has] reduced stability in the home" and "I was not told the old manager had gone. I was not introduced to the new one. Communication is bad."

Relatives complained about the lack of an open culture at York Court. They told us residents meetings took place at the home, to which they were invited, to discuss service delivery and for them to give feedback. However, we were told that the last three meetings were cancelled and rearranged at short notice and this had caused inconvenience to some people who had not been made aware of the cancellations. Relatives consistently complained that despite giving feedback, their comments had not been acted on in any way. Comments included "Meetings are cancelled at the last minute" and "I'm not kept informed of meetings." We spoke with the interim manager and regional manager about the cancellation of relatives meetings. The regional manager explained that they had to rearrange the last meeting to ensure they were able to attend. Neither the interim manager nor the regional manager were able to explain the reason for previous cancellations of meetings. The service did not use any other mechanisms to obtain feedback from people.

Both the interim and regional managers acknowledged the failings of the service and told us they were committed to improving the standards at York Court. Relatives we spoke with after the inspection spoke positively about their interaction with the new interim manager and said they felt their concerns were now starting to be acknowledged. Comments included "She's an honest lady" and "She's listening to us."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The registered person had not made suitable arrangements to ensure that service users were safeguarded against the risk of abuse because they had not taken steps to identify the possibility of abuse before it occurred or responded appropriately to allegations of abuse. Regulation 13.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered person did not have suitable arrangements to ensure that persons employed for the purpose of carrying on a regulated activity were appropriately supported to enable them to deliver care to people safely by providing appropriate training, professional development, supervision and appraisal. Regulation 18.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered person had not ensured that service users were enabled to make, or participate in making, decisions relating to their care or treatment or that service users were treated with consideration and respect at all times. Regulation 9.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

This section is primarily information for the provider

Action we have told the provider to take

Treatment of disease, disorder or injury	The registered person did not have an effective system in place that ensured that complaints were fully investigated and, so far as reasonably practicable, resolved to the satisfaction of the service users, or people acting on their behalf. Regulation 16.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person was not protecting service users against the risks of inappropriate or unsafe care because they did not regularly assess and monitor the quality of the services provided and did not identify, assess and manage risks relating to the health, welfare and safety of service users and others. Regulation 17.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving inappropriate or unsafe care as are was not consistently planned and delivered in such a way as to meet the service user's individual needs or ensure their welfare and safety. Appropriate emergency procedures were not in place. Regulation 12.

The enforcement action we took:
We have issued a warning notice to York Court in respect of this regulation.