Care UK Community Partnerships Ltd

Davers Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 16 and 17 February 2016 and was unannounced. The service had previously been inspected in January 2015 when it was found to be in breach of regulations related to the management of medicines and the obtaining of consent.

The service provides accommodation and nursing care for up to 60 people, some of whom are living with dementia. At the time of our inspection there were 56 people resident. The service is divided into four almost identical wings. One wing was a nursing unit and had ten designated beds for people who had been discharged from West Suffolk Hospital for temporary care.

The service had had six managers since opening in August 2014. A registered manager was not in post at the time of our 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.

Medicines were not always well managed and some medicines had not been administered as people were asleep or refused. Records related to medicines were not accurate. We also found that stock control methods did not monitor tablets accurately which meant any administration errors would not be obvious to staff. Staff altered records related to medicines which meant they did not represent an accurate and contemporaneous record.

Staff were trained in safeguarding people from abuse and they understood their responsibilities with regard to keeping people safe and reporting suspected abuse.

Risks were assessed but the service was not always proactive about managing risk. The service carried out audits to monitor health and safety but we had been previously informed of an incident in which a section of coving had come down causing injury to a person who used the service. We have found that several sections of coving had fallen since the service opened and we are continuing to investigate this matter.

There were not enough staff who had the required skills, knowledge and experience. Agency and newer staff did not demonstrate that they knew people well, although permanent staff were found to be skilled and competent.

Staff received the training and induction they needed to carry out their roles effectively but some agency staff did not receive a comprehensive induction.

We saw that staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards DoLS) and the service acted in accordance with them. The MCA ensures that people's capacity to make decisions is assessed. Where people lack capacity to make decisions for themselves, decisions are

made in their best interests according to a structured process. DoLS ensure that people are not unlawfully deprived of their liberty and where restrictions are required to protect people and keep them safe, this is done in line with legislation.

People who used the service were not always positive about the food and the service had worked hard to engage with people and improve this aspect of the service. People identified as being at risk of not eating enough were referred to the dietician and monitored to ensure no further unplanned weight loss. People were also supported to access other healthcare professionals when they needed them although we had concerns about one person who we observed did not receive prompt healthcare support during the course of our inspection.

Staff were caring, passionate about their work and committed. We saw that some staff demonstrated innovative practice and acted as excellent role models for newer members of staff. People were treated respectfully and their dignity was maintained in most cases but we did also see some examples of very poor practice that impacted on the dignity and wellbeing of two people in relation to personal care needs.

People were involved in assessing and planning their care but were not always supported to follow their own interests and hobbies. Some people living with dementia had very little stimulation or activity. We saw no evidence of 'Activity Based Care' which is a Care UK initiative to involve people in the everyday life of the service.

Formal and informal complaints were managed well. People who used the service, and their relatives, were consulted about the running of the service but the management team did not always listen to people and change did not always follow. Staff understood their roles and were positive about the current management team.

Systems to monitor the quality and safety of the service were not robust and did not always protect people effectively.

We found several breaches of regulation during this inspection. You can see what action we have told the provider to take at the back of this report.

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.

Medicines were not always administered safely and stocktaking measures did not always ensure people had received the correct amounts of their prescribed medicines.

Staff were trained in keeping people safe from abuse but risk management was not consistently good.

There were not always enough skilled and experienced staff.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received the training they needed although some staff had not been trained to use a particular recording system for medicines.

The service was working in accordance with the MCA and DoLS..

People were not always positive about the food but the service had been trying hard to engage with people to bring about improvements.

People were supported to access healthcare professionals when they needed them but the service was not proactive in managing everybody's health. Staff worked well in partnership with other healthcare professionals to support and care for people staying temporarily following discharge from West Suffolk Hospital

Is the service caring?

Requires Improvement

The service was not always caring.

Many staff were caring and treated people with respect and kindness and involved them in decisions about their care.

We observed good relationships between the staff and the people they were supporting and caring for.

Not all care was proactive and for some compromised their dignity and caused embarrassment.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were involved in assessing and planning their care as much as they could be.

There was a mixed picture regarding people following their own interests and hobbies. Some people were positive about how they were able to spend their time but many were not and people living with dementia had very little to do.

Complaints were well managed.

Is the service well-led?

Requires Improvement

The service was not well led.

People and their relatives were consulted about the service but change did not always follow.

Staff understood their roles but staff morale was low. There was confidence in the new manager to bring about improvements.

The auditing of the service was not effective and there was a lack of oversight from the management and Care UK as a provider.

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

The inspection took place on 16 and 17 February 2016 and was unannounced.

The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert had experience of caring for someone who used this type of service.

Before we carried out our inspection we reviewed the information we held about the service. This included any statutory notifications that had been sent to us. A notification is information about important events which the service is required to send us by law. We also reviewed the previous inspection report from 14 January 2015 and the action plan which the service had supplied following this inspection.

We spoke with eighteen people who used the service, nine relatives, four nurses (including one agency nurse),eight care staff (including two agency staff), four senior care staff, the lifestyle co-ordinator, two members of the housekeeping staff, the chef, the deputy manager, the operations support manager, the service manager and the regional manager. We also spoke with four staff employed by West Suffolk Hospital who, along with Care UK staff, provide short term care for up to ten people on the nursing unit following their discharge from the hospital. We gained feedback from one local GP and spoke with members of the local authority safeguarding, quality and improvement, and contracts teams. We also observed a relatives meeting which 14 relatives attended on 17 February 2016.

We reviewed nine care plans, eight medication records, two staff recruitment files, staffing rotas for the previous ten weeks and records relating to quality assurance and the maintenance of the service and its equipment.

We observed staff providing care and support and 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 communicate with us easily.

Inadequate

Is the service safe?

Our findings

When we last inspected this service on 21 January 2015 we found it to be in breach of regulations with regard to how they managed medicines. At this inspection we found that the service had not made the required improvements to ensure medicines were always managed safely. Feedback from people who used the service was mixed about how staff support them to take their medicines. One relative said, "They stand and wait while[my relative] takes his tablet" while another relative told us that medication had been , "A big problem" as staff had failed to give their relative their medication successfully for several days.

There were suitable arrangements in place for the ordering and storing of medicines, including controlled drugs. Staff received training in how to administer medicines and this was updated appropriately and their competency to do so was checked. However we spoke with two nurses who were completing their induction and had received training on a particular recording system. The majority of medicines administered by nurses was recorded using a different system. Safety of medicines administration was compromised as nurses were trained and given a policy and procedure to follow by their employer, but were asked to regularly use a different system that they had not been trained or assessed as competent to use.

We observed medicines being administered to people on three units and saw that staff demonstrated a compassionate and caring attitude when they gave people their medicines. We observed that staff identified they had the correct person and the correct medicine before they administered it. However on one occasion a nurse referred to the Medicines Administration Record (MAR) chart and saw that there were no painkillers in stock for that person and used another person's prescribed medicine instead. This compromised the safety of medicines management and increased the likelihood of mistakes being made. In addition the nurse was not following the policy and procedure set down by Care UK or following the Nursing and Midwifery Council guidelines.

We saw that people's wishes about how they took their medicines were recorded and staff gave people sufficient time to take their medicines and ensured that they had taken them before moving on to the next person. We observed one member of staff being very patient with one person who had trouble swallowing tablets and held them on their tongue for several minutes. However we noted, from the minutes of a relatives meeting held 16 January 2016, that a relative had raised a concern about their relative being found with medicines for Parkinson's disease which they had not swallowed. This meant that staff had not been so vigilant on that occasion.

People told us that they received their medicines on time and we observed that medicines were mostly given in a timely way. However two medicines caused us concern. The first was medicine for a person's Parkinson's disease. This time sensitive medicine was administered more than two hours late but the record reflected that it had been given at the correct time. Therefore the gap between medicines would either be too long or too short when the next medicine was prescribed which placed the person at risk of deterioration in their condition.

The second medicine related to the administration of Morphine [a controlled drug]. We found gaps on the

MAR chart where staff should have signed to confirm medicines had been administered. We made enquiries about the gaps and fed back our concerns to management. We were requested to look again at this chart a little later. When we did this we found that the chart had been altered twice in retrospect. There were fewer gaps than previously and codes alongside initials were used. This was therefore not an accurate contemporaneous record and did not follow the policy and procedure in place.

We were concerned that there were records of people failing to receive their medicines either because they were asleep or had refused to take them. For example we saw that one person had failed to receive any of their prescribed medicines, which included medicines for depression, heart disease and thyroid function, on five occasions in a 25 day period. Another person had failed to receive the medicines for their heart condition on three occasions within a six day period. On each occasion the reason was given was that the person was fast asleep. We noted that out of the eight records we viewed four people's records contained evidence that they had not received medicines as they had been asleep or had refused. The service were documenting when this happened but did not have a proactive approach to reducing the frequency this occurred. We also noted that the handover we observed on 17 February documented that of the thirteen people on one unit, four had refused their medicines that day, with one person also refusing at lunchtime.

We found that stocktaking procedures were not always efficient as the MAR charts did not always show the amount of medicines which were carried forward from one month to the next. This had been noted in recent medicines audits but the situation had not improved. We saw that the stock of one person's Warfarin did not accurately match the recorded amount. This meant that we could not be assured that people had always received the correct amount of medicines.

This was a breach of Regulation 12 – 1, 2 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that risks related to a variety of needs such as moving and handling, pressure care, eating and drinking and mobility were assessed and actions to reduce these risks were documented. We found evidence of good practice on one unit where one person was very allergic to fish. We saw that they sat on their own table to reduce the risk of other people giving them food or them helping themselves. Products containing fish were not allowed on the unit and risks were clearly documented. However one person, who had an identified risk of choking was seen to be eating food which posed them a risk as it was not of the correct consistency.

We noted that there had been five falls on the dementia unit in the 24 hours prior to the inspection. We saw that one person had a bruise on their forehead and asked staff about this. They told us, "He's prone to falls". Falls for this person were documented in their electronic record and the person had been referred to the GP, mental health team and falls prevention team for assessment.

Staff showed us the risk assessment that they completed each time a person had a fall. They told us this was FRASE. They did not however know what that stood for (it stands for Fall Risk Assessment Scale for the Elderly and is a recognised assessment tool). After each fall staff reassessed the person and recorded the new FRASE score, however some staff we spoke with were not clear about proactive intervention to reduce falls for people.

The new manager attended a daily meeting with senior staff to assess current issues within the service. This meeting covered new and potential risks and the manager outlined new guidelines for staff to follow when someone fell. It was hoped that a more structured approach would result in more consistent management

of people's risks.

Staff were able to tell us what they would do if they suspected or witnessed abuse and knew how to report issues both within the company and to external agencies. Staff had received training in safeguarding people from abuse and were aware of the service's whistle blowing policy. Our records showed that the service had reported safeguarding concerns appropriately and had worked with the local authority to investigate any concerns raised.

People who used the service and their relatives fed back a mixed picture about whether they felt the service was safe. Some told us they felt safe and had confidence in the staff to keep them safe. Others were more concerned. Three relatives told us that they had particular concerns about other people who use the service going into their relative's bedroom. One person said, "[My relative] feels safe here but [their] door has to be locked because the [resident] next door goes into [their] room". Another relative was concerned about the behaviour of some of the people who used the service and told us, "I have seen aggressive behaviour – three [residents] squaring up to each other on a very regular basis".

We noted that the service had worked with relevant healthcare professionals to develop care plans for some of the people who occasionally displayed distressed reactions to things going on around them and who could behave in a manner that was perceived as threatening to others. We saw that strategies to support people's behaviour were documented but our observation was that these were not always put in place, often because not all staff working in that area of the service were familiar with people's needs. We observed one person become very agitated but staff did little to communicate with the person to try and understand what the concern was or distract them. A member of staff had designed communication cards for this person as their first language was not English but these were not used and could not be located at all on the first day of our inspection. Staff who knew people well responded quickly and effectively to diffuse situations but our observation was that there was often only one experienced member of staff on each unit. Staff also told us that this was often the case with one commenting, "This is a reasonably typical day. Usually one strong team member and others follow".

People who used the service, their relatives and staff had a range of opinions on the staffing of the service. Staff told us they were often short staffed. One person said, "People are not getting quality, we are often short". Some people acknowledged that staffing was not consistent but felt it did not have a negative impact on their care. One person said, "Whenever we ring the bell someone comes…it's difficult to know who's who but I always find someone to help me". Others were more negative with one person saying, "There's no continuity of staff", and another, "Staff change all the time".

We asked to see the call bell logs for two days in the fortnight leading up to the inspection. These showed that bells were responded to promptly by staff in the majority of cases and this was our observation during both days of the inspection. In the call bell log we saw that on only three occasions people had to wait more than five minutes and one person waited more than nine minutes for a response on one occasion. On each of these occasions the reason was given that staff were already assisting other people. The service kept call bell response times under review.

The main staffing issue related to the skills and experience of staff, particularly new and agency staff, as well as a lack of a strategy about where best to deploy them. Our observation was that on some units staffing did not always show that thought had been given to the skill mix of staff and to the dignity needs of people who used the service. For example people raised concerns about their female relatives being supported by male carers when they had asked for female carers only. One relative said, "[My relative] is supposed to only have female carers but it's often men at night".

We looked at rotas and identified that some shifts, particularly night shifts, had run with a high proportion of male staff and of agency staff. Mostly we saw that two and occasionally three of the six or seven night staff were male. However one shift in February had run with five male and two female members of staff, five of these were agency staff. Rotas documenting the staffing on night shifts during the first two weeks of February showed that there were at least two agency staff employed on eleven occasions, with one night documenting that there were four. This meant we could not be assured that people's needs would be met at night as staff were not always familiar with people's needs.

This was a breach of Regulation 18 - 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff employed at the service had been through a thorough recruitment process before they started work. Permanent and agency staff had checks in place from the Disclosure and Barring Service to establish if they had any criminal record which would exclude them from working in this type of setting. All appropriate checks of permanent and agency staff had taken place before staff were employed to work at the service.

Requires Improvement

Is the service effective?

Our findings

People who used the service, and their relatives, reflected a mixed picture with regard to the skills and experience of the staff. People praised various members of the permanent staff team and we found some members of staff to be skilled and innovative and give consistently high quality care. We saw written testimony from one relative about a team leader which commented on their 'outstanding understanding of identifying and dealing with what borders on clinical decision making'. One person who used the service said, "Most carers are pretty good…but there are a lot of younger staff who are very inexperienced". A relative commented about the agency staffing at night saying, "They don't know [my relative]… I can tell if [they] have had a bad night….Agency staff maybe why".
Permanent staff had the skills and knowledge to support people in their care. Staff told us that they received regular training which was kept up to date. We tracked two staff in detail and found that they had received the training they needed to carry out their roles effectively. Staff explained that additional training was given to meet people's individual needs. An example of this was training in diabetes and falls awareness. We were however concerned that some staff were not aware of information relating to skin care and could not describe and categorise pressure ulcers. Nurses told us that they had the clinical skills to meet the needs of people they were responsible for and recent training had included catheter care and verification of death, although this was not recorded in the training records supplied to us.

Staff undertook an induction when they joined the service and carried out training which covered core skills such as moving and handling people, infection control, food safety and medication administration. Staff were able to shadow more experienced members of staff for a number of shifts to help them gain both competence and confidence before working as part of the permanent staff team. An induction was in place for agency staff and records confirmed this had taken place for agency staff on duty on the day of our inspection.

We observed a handover to a senior agency staff member who was going to be leading the night shift covering two units. Two permanent staff were also on duty but were not present at the handover. One staff member had been in post only six weeks. The agency staff member had been at the service once before but were not familiar with the people who used the service or the systems used to document people's care. They did not know how to use the electronic records system and took notes down on a notepad during the handover. They asked questions about people's most basic caring needs only, such as who has a fluid chart in place and who needs two care staff to support them with their mobility needs. The staff member handing over was also not clear about one person's needs saying, "They might be on a fluid chart, look in the books".

It was not made clear to the agency staff member which people had a Do Not Attempt Resuscitation order in place or where to find this information. There was further information in a folder on each unit to help guide staff but this was not detailed. The handover on the nursing unit, where there was a high usage of agency nurses, demonstrated that while it was detailed and informative, systems to communicate information between shifts were not clear. This placed people at risk.

We observed the practice of some agency staff which demonstrated that they did not know people well and

permanent staff were not always nearby to guide them. We saw agency staff filling in people's fluid charts before they had had their drinks, forgetting who people were and failing to communicate effectively with people.

This was a further breach of Regulation 18 - 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care staff demonstrated an understanding of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). We observed throughout the day that people's consent was asked for before care and treatment was provided. Staff mostly took time to offer choices to people appropriately and waited for their response, although we did see some less good practice from staff who did not know people well. Decisions and consent in matters such as resuscitation if a person's heart stopped were appropriately decided and known about as there was discreet signage to guide staff on most units.

People's capacity to consent was well documented in their care plans. For example one person had been involved in the development of their care plan but had been unable to be fully involved due to their dementia. They were able to state their day to day preferences and we saw that their relative had been appropriately involved for more significant decisions. The service understood its responsibilities with regard to DoLS and had submitted appropriate applications to the local authority for consideration.

People who use the service gave us mixed feedback about the food. Some people were very positive saying, "There's lots of food that I like" and "The food is lovely". While others were more negative. One person summed this up and told us, "The food could be better. Tea is beautifully presented but there's always the same tea and cakes". Another person said, "There's not enough traditional food".

Concerns had been raised, both in person and in meetings, about the type of food and requests for plainer food had been made. We saw that the service had made a great effort to engage with people and respond to concerns and progress had been made. On the day of our inspection both meals were not particularly plain (seafood fricassee and sweet and sour chicken) but they were quite well received. We observed the chef coming round to discuss people's dietary preferences with them in great detail. They spent a long time with one particular person who has been losing weight, due to a decreased appetite, to try and establish what might tempt them to eat more. They were kind and patient and were clearly very keen to help and support this person with their eating.

We observed mealtimes on two different units and had two very different experiences. On one unit the atmosphere was calm with music playing. Staff took time to offer choices of food and drink to people. Some people chose to eat in their rooms. All people were offered support and encouragement where needed. On the other unit the mealtime was chaotic, with some people waiting a very long time to be served and supported to eat their food. During the meal two people had to leave for urgent personal care needs which should have been anticipated by staff before the meal was served. This meant that the experience for these two people, and others, was not pleasant. New and agency staff did not know how to offer people choices in a way they understood which led to confusion. We also noted at breakfast that a new member of staff had provided the wrong type of food (toast) for someone who was on a pureed diet. This placed them at risk of choking.

We saw that care plans contained information about people's dietary likes and dislikes and where people had been assessed as being at risk of not eating or drinking enough, this was monitored. We noted that people's weights were regularly recorded and where people had lost weight we saw that they had been referred to the appropriate healthcare professionals. Food charts documented what people had eaten but

we did not see that high calorie snacks had been recorded for people who needed to maintain or gain weight. Staff told us this was a records issue rather than a reflection that they had not been provided.

The service had an event each day called, 'tea at three'. This was where everyone in the building was encouraged to stop what they were doing and go and have a cup of tea with people who lived at the service. This not only encouraged people to drink, but also emphasised the importance to all the need to socialise around refreshment time.

Records showed that people had access to a variety of healthcare services including GPs, district nurses, psychiatrists, opticians, dentists and chiropodists. On the nursing unit ten of the beds were 'step down' beds from West Suffolk Hospital. People were transferred from the hospital who were medically fit but would benefit from further assessment, treatment or support. People typically stayed for two weeks. They would then either return home or find a suitable service which would meet their care needs on a permanent basis. A team of medical clinicians worked on this unit including a discharge and planning practitioner who was available seven days a week, rehabilitation staff such as occupational therapist and physiotherapist, and a consultant who visited at least weekly. There was also support from a regular pharmacist technician from the hospital. This enabled people using this part of the service to have effective access to appropriate healthcare support.

We received positive feedback from a local GP regarding how the staff made appropriate referrals. They commented on how one staff member had stayed with a person they had just seen on the day of our inspection and how much this was appreciated by the person. We saw that people had been referred to a speech and language therapist (SALT) if they developed problems swallowing. We noted that recommendations from the SALT had been incorporated into a person's care plan and staff were following this guidance, other than the incident documented earlier in this report.

We observed that the service did not respond promptly to the deteriorating condition of a person during our inspection. The person was new to the service and had been increasingly unwell and unwilling to take their medicines. Information about this person's needs was not detailed and staff were observed to struggle to meet their needs. During the second day of our inspection the person deteriorated significantly. At the evening handover to a senior agency staff member we noted that although the GP had been called twice during the day, they had not come out and the person was now in bed. Advice given to the agency staff member was not clear and we discussed our concerns with the manager, operational support manager and the regional manager. The operational support manager assured us they would ensure a GP came to review the person that night. When we phoned the following day for an update we were informed that no GP had been contacted the previous night and the person had been admitted to hospital the following day as an emergency.

Requires Improvement

Is the service caring?

Our findings

People had care plans which contained information about their life histories including their family background and important relationships. Permanent staff knew people well and spoke knowledgeably about people's likes and dislikes. Newer and agency staff were not so informed and we observed staff who were not clear about people's life histories or the best way to meet their needs in a way which maintained their dignity. For example we saw agency staff speaking to one person whose first language was not English. They did not know that the service had developed communication cards to help this person understand what was being discussed. We saw that this lack of understanding meant that this person was offered little choice and decisions were made for them rather than with their involvement. The communication cards could not be located at all on the first day of our inspection but were used to good effect on the second.

Another person was observed to require personal care during the lunchtime meal. They got up from the table and their incontinence pad fell down. This happened two more times until a member of staff escorted them from the dining room with their hand holding the pad in place. Another person's stoma bag overflowed whilst they were eating their lunch. Their pyjamas, which they were still wearing at lunchtime, were soaked in faeces. They too were escorted out of the dining room. This person had been observed throughout the morning and had been sitting in the same chair in the dining room for almost four hours. They had not had a wash, shave or their hair brushed. We asked a permanent member of staff if the stoma bag overflowed often and told us, "Yes it does lately – and usually at mealtimes". We checked records and found that this had happened nine times in the last four weeks. Both the incidents we witnessed at lunchtime and the frequent episodes where one person's stoma bag overflowed represented a serious failure to maintain people's dignity.

This was a breach of Regulation 10- 1-of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Two relatives raised a concern about the number of male staff working the night shift on of the units which had mainly male residents. They were concerned that their female relative had received personal care from a male when this was against their wishes. We noted that although people were asked if they had a preference related to the gender of staff who provided their personal care, it was not documented in the current care plan. We raised this issue with the management of the service who assured us they would address this.

We also observed some good practice with regard to maintaining people's dignity and independence. For example one person had a key safe outside their door so that when they used the call bell, staff would come and unlock their door and knock before entering. This was at the request of the person using that room as they valued their privacy. Staff had enabled this to happen effectively.

People told us that they found the staff caring, friendly and kind. Throughout our inspection we observed that staff had formed meaningful and positive relationships with the people they were supporting and caring for. One member of staff was seen kneeling with an elderly lady, holding their gaze and giving

reassurance with a stroke of their hand gently saying, "It is OK". One relative told us, "I am very satisfied with the care. I visit most days. Staff are very caring." Another relative said, "The care staff are so patient and caring and they talk to [my relative] a lot".

We observed that people were treated with warmth and kindness and staff were quick to reassure people if they were confused or upset. We observed one senior carer taking time to sit with someone who had become distressed. They chatted to them and gently stroked their hand which gradually calmed them. We also observed the same member of staff speaking to a relative who had a particular concern about their relative's care. We saw that they took time to listen and try and reduce their anxiety.

We found that people were routinely consulted about every day decisions. Our observations were that staff enabled people to be involved and respected their choices with regards their daily care, choice of meals and of how to spend their day. We saw that care plans documented the level at which people could contribute to their care plans and who else was to be consulted with decisions.

Requires Improvement

Is the service responsive?

Our findings

People told us they felt there were not enough opportunities for people to follow their own interests and hobbies. People were especially critical about the lack of one to one opportunities for people living with dementia to take part in an activity. One relative said, "There should be more one to one activities; they're always sitting around sleeping". Another person commented, "The only activity is going to the cinema". A third person praised the lifestyle co-ordinator but said that there was still too little to do and no trips out.

The service had a fully equipped cinema and had scheduled showings of films however the scheduled film was not shown on the first day of our inspection and only two staff and no residents were seen when a film was shown on the second day. We observed one person living with dementia being given some sensory equipment which engaged them for a short while but this was the only time we saw any specialist activity for people with this condition.

People played cards and there were some ball games but the lifestyle co-ordinator conceded that it was difficult to provide stimulating activity for everyone on a regular basis. They had produced a five minute activity crib sheet to guide staff but staff did not appear to have the time, and in some cases, the knowledge and understanding to put these in place. People told us they really enjoyed it when singers came to entertain them and would like to have this happen more often. We noted that a number of activities had taken place over the Christmas period and a variety of entertainers had visited the service.

The service website states that it promotes 'Activity Based Care' which was described as people being actively encouraged to play a part in the life of the service, whether this be laying the table, popping to the shops or pottering in the garden. We found very little evidence to support that this was taking place.

People's needs were assessed before they moved into the service. The routine assessment for people moving onto the nursing unit included a hospital assessment which was followed up by a manager from the service carrying out their own assessment to ensure that the service could meet the person's needs. We viewed several assessments for various units, including those for two people who moved into the nursing unit on the day of our inspection, and saw that they were robust.

The service had a system of 'Resident of the day'. This meant that a person's care was evaluated once a month. The new manager wanted to expand this experience and invite the relatives to be part of this process with the service user's consent. We found that improvements to the current system were needed. Staff told us that on occasion the person updating the care plan on the set day may not know the person they were evaluating. Staff explained to us that they were often moved to units when staff were short (we saw this had occurred on the day of our inspection). We were shown an example of where a person who was not familiar with a person's needs had updated their care plan. Another staff member said that they too had competed similar documents for people they were not familiar with. This meant there was a risk that people's needs would not be fully understood or actions put in place to meet them.

We saw that resident meetings took place regularly and a meeting had been held recently to discuss what

new things people might like to try. A number of suggestions were being taken forward as the manager was keen to increase the opportunities for people to follow their own interests and hobbies if at all possible.

Resident and relatives meetings took place regularly and feedback was actively sought on how the service was performing. However we found that there was frustration from some people who used the service and their relatives that little change followed. One person said, "Usually nothing changed". We did however find that the latest meeting, which we attended on the second day of our inspection, was viewed much more positively.

This meeting was well attended by 14 relatives and one person who used the service. The purpose of the meeting was to give information on developments and changes within the service. This was done effectively. Minutes were kept and further regular dates were planned for the coming year. Each person attending was given the opportunity to speak and express their view. People were listened to and actions agreed to resolve or address concerns. Themes discussed included the food, activities and staffing. Where people needed to discuss more individualised concerns arrangements were made by the manager to see people that week. This ensured that people's information was confidential to them and not shared inappropriately.

The service had a complaints policy and procedure and people, and their relatives were aware of these. We saw that there was a record of 13 complaints recorded in the last three months. Records were not complete but we saw that the majority of complaints had received a written response and had been resolved.

Requires Improvement

Is the service well-led?

Our findings

We found that records were not always accurate. Electronic records were good but systems were not well understood by everybody, especially agency staff who told us they wrote things down and staff transferred information afterwards. There was an agency log in for the electronic system but the agency staff we spoke with did not use it. We asked one member of staff to show us how to bring up records from previous weeks and they were not clear, although did so eventually.

We found that sometimes information was recorded differently in different places. For example one person's care plan said they should be repositioned every four hours, another said every three hours and a staff member said every two hours. This person was being repositioned and was well but records for this person did not provide clear information for staff, especially agency and newer members of staff. Another person's care plan did not document that they had received any mouth care during February and only four times in January. Staff told us this was a records rather than a care issue. Some food charts did not contain accurate information as not all snacks had been recorded.

The completing of fluid charts before drinks had been served and the altering of records relating to medicines on the nursing unit meant that these were not accurate and contemporaneous records.

This was a breach of Regulation 17- 1, 2 c -of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service has not been led by a consistent management team since it opened in August 2014. The current manager, who had only been in post a matter of days, was the fifth manager to have management responsibility for this service. The new manager had quickly identified the most pressing challenges facing the service and discussed various strategies they wished to implement. They were observed taking questions from anxious relatives at the monthly meeting and we found their approach skilful, honest and fair. Staff were very positive about the new manager at this early stage in their leadership. One member of staff commented, "The new manager is proactive. She could be right for us. We have had six of them and there are changes all the time". The new manager had given the daily heads of department meeting a clearer focus which meant that the management of the service were more able to have an accurate overview of issues within the service on any given day.

People were not always clear about who the manager was, which was understandable given the number of changes at the service. Three relatives raised with us a concern about a lack of management oversight in the evenings and at weekends. One person said, "There's never a manager here at night for the 8pm changeover. No manager here last weekend, all weekend". We asked the operational support manager about this and they assured us that management were often at the service but admitted that they did not always sign in and we were not able to verify this from any record. There was an appreciation that this was an area to be improved upon. We did, however, see evidence of out of hours spot checks carried out by the operational support manager as part of their monitoring role.

The service had most recently been managed by an operational support manager. They had been in post since October 2015 and were staying on to hand over to the new manager. We received positive feedback about the operational support manager from both relatives and staff. One relative said, "[They] are good, and you can tell when they're in the building" and a senior member of staff commented, "[They] are accessible and approachable if you have a problem, which is very helpful". . Whilst there had undoubtedly been positive aspects to their leadership we also saw that some issues had not been effectively addressed as highlighted in the breaches of regulation within this report.

People who used the service, staff and relatives were consulted about the running of the service and regular meetings were held with all these groups. We looked at minutes of recent meetings and saw that often the same issues were discussed. For example concerns about the menus were discussed at the last three resident and relatives meetings with little appearing to be resolved. The minutes were not professional and did not always document who attended or who raised particular issues. Minutes sometimes reflected decisions management had taken rather than genuine consultation. For example, in response to a concern about the food raised at a meeting in November 2015 it was recorded that 'changes in taste will happen'. The inference was that people would come to like this food. Another discussion about the food at the January 2016 meeting records that the operational manager said that 'the new bank chef has a passion for oriental food' and the operational manager suggested that an oriental or foreign meal is trialled once a month which is the opposite of what people had actually been asking for.

We also noted that minutes sometimes recorded significant issues, such as one person having no duvet one night as staff could not find one, or a relative raising a concern that their family member had been given their medicines but staff had not checked to make sure they had taken them and they remained in their mouth. The relative had informed a senior member of staff but they had taken no action. These issues of poor practice were noted in the minutes but it was not clear what action was proposed to ensure the situation did not happen again. Indeed excuses were noted in relation to the medicines incident with the minutes stating 'some [staff] get scared about taking responsibility'. This attitude does not reflect an open and transparent culture where management take responsibility when things go wrong.

We saw that there was a new wellbeing project for staff. The idea was for staff to offer up suggestions as to how the service could be improved and for staff to vote on their favourite and for this to be taken forward. The management had not begun to evaluate responses but we saw that the vast majority were very negative and related to a perceived lack of support for staff. It was clear from this that morale at the service was low. This was also confirmed by the most recent staff satisfaction survey which was carried out in November 2015. The survey had identified a number of issues which staff were unhappy about and information was broken down to provide clear data but the action planning section had been left blank and it was not clear what had happened as a direct result of staff feedback. The section called 'I believe that action will be taken in response to this survey' reflected that only 10% of respondents thought this would be the case.

Audit systems were in place and monitored a variety of aspects of the service including health and safety, call bell response times and medication. We saw that the audits had not always identified the issues that we found at inspection and where issues had been identified action did not always follow to improve the service. For example the medication audit showed that it had been identified in the December 2015 audits of all units that stocktaking was not effective as some medicines had not been carried over. This was also noted on the February 2016 audit. We also identified issues with poor stocktaking during our inspection. The call bell response times were audited and closely monitored which meant that any concerns could be quickly identified.

Despite the audit programme and initiatives to improve the service we found that there had been a lack of

management oversight. Whilst we could see that a great deal of effort had been put into bringing about positive change in some areas, this was not the case overall. There was a lack of a coherent strategy with regard to the deployment of staff with the required knowledge and experience in some areas of the service. The issues with people failing to receive their prescribed medicines had not been identified by any audit and staff morale had been seen to be low in November 2015 but effective strategies had not been put in place to address this at the time of our inspection. Care UK, as the provider, have not been proactive in ensuring a consistent leadership that has evolved from learning from feedback and incidents to create a high quality service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure that people who used the service were treated with dignity and respect. Regulation 10 - 1.

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 failed to maintain an accurate, complete and contemporaneous record in respect of each service user. Regulation 17 - 1, 2 (c)

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 failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff. Regulation 18 - 1.

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
Treatment of disease, disorder or injury	The provider failed to ensure the proper and safe management of medicines. Regulation 12 - 1, 2 (g)

The enforcement action we took:

Served a warning notice