Bupa Care Homes (CFHCare) Limited

Manor Court Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: Manor Court is a residential care home that provides personal and nursing care for up to 111 people. The service is divided into four units. Three units are for older people and one unit is for younger adults with physical disabilities. At the time of our inspection 82 people were living at the service, 23 were younger adults. Some of the older people were living with the experience of dementia. The service included four residential buildings on one site. Each building made up one unit, which was self-contained with its own communal facilities. Beech and Larch units provided accommodation for people who were living with the experience of dementia. Willow unit provided accommodation for older people. Sycamore unit provided accommodation for younger adults with physical disabilities. Some people also had learning disabilities.

People's experience of using this service:
People were not always being safely cared for. They were placed at risk of harm and abuse because there were not enough preventative measures taken to keep them safe.

The risks to their safety and wellbeing had not always been assessed or planned for. This meant that the staff did not have the information they needed to mitigate risks and keep people safe.

Medicines were not always managed in a safe way and this meant people were at risk of not receiving the medicines they needed safely.

There were not always enough suitable staff deployed to meet people's needs and keep them safe.

The provider's systems for monitoring and improving the quality of the service had not been effective, because people were not always receiving a good quality of service and risks had not been mitigated.

Records were not always accurately maintained or up to date. This meant that people were at risk of receiving care which was not appropriate.

The provider did not always act in accordance with the Mental Capacity Act 2005. Therefore, people had not consented to their care and treatment and decisions had not always been made in their best interests.

People did not always receive personalised care which reflected their needs and preferences

Some people using the service were happy and experienced kind care and support.

People had access to healthcare services and the staff worked with other professionals to make sure people stayed healthy.

People had enough to eat and drink.

People being cared for at the end of their lives received the support and care they needed.

Rating at last inspection: The last inspection took place on 26 June 2018. At this inspection we rated the service good overall and for all of the key questions we ask.

Why we inspected: We carried out our inspection of 29 January 2019 because we had been alerted to concerns about the service. These included medicines errors, unexplained injuries and other safeguarding concerns. The local authorities who commissioned services with the provider and who carried out safeguarding investigations, had shared their concerns about the service with us.

Enforcement: We are taking action against the provider for failing to meet Regulations. Full information about CQC's regulatory responses to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

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

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

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

Follow up: We will continue to monitor the service and will undertake another comprehensive inspection within six months.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our Safe findings below	**Inadequate**
Is the service effective? The service was not effective Details are in our Effective findings below.	**Inadequate**
Is the service caring? The service was not always caring Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

Manor Court Care Home

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted by a high volume of incidents which took place at the service in the past three months. These included unsafe medicines management, unexplained injuries and allegations of neglect. The individual incidents were subject to investigation by the local safeguarding authority and, as a result, this inspection did not examine the circumstances of the incidents.

However, the information shared with CQC about these incidents indicated potential concerns about the management of risks. The inspection examined these risks and the provider's response to them.

Inspection team:
The inspection team included three inspectors, a member of the CQC medicines team, a nurse 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.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

The inspection took place on 29 January 2019 and was unannounced.

What we did:

Before the inspection we looked at all the information we held on the provider. This included notifications from the provider. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We met with the local authority who discussed visits they had undertaken to the service and concerns they had about the way risks were being monitored and mitigated.

During the inspection visit we spoke with 11 people who used the service and six visiting relatives and friends. We also spoke with two visiting external professionals.

We spoke with the staff on duty who included the deputy manager, nurses, care workers, activity coordinators, healthcare students on placement at the service and temporary staff sourced from an employment agency. The registered manager was on leave at the time of our inspection, but we met with the provider's representatives, who included the regional director and regional support manager.

We observed how people were being cared for and supported. Our observations included using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not speak with us.

We looked at records at the service which included, nine whole care plans and parts of a further eight care plans, records of accidents, incidents, complaints, safeguarding alerts, meeting minutes, audits of the service, staff training and support records and the recruitment records for six members of staff.

Following the inspection visit, we met with the regional director, regional support manager and deputy manager to share feedback about our findings.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Whilst some people told us they felt safe, others said that they did not. Their comments included, ''They [staff] pull my arms to get me up and it hurts, if I say something they think I am too fussy'' and ''I do not always feel safe, it is such a big place and sometimes I feel pushed into doing something I don't want to.'' The relative of one person told us, ''[Person] has told me that the staff are sometimes a bit rough with [them]''

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● People were not always protected from improper treatment and abuse. Since the beginning of November 2018, there had been ten serious incidents.

● Four of these incidents resulted in people sustaining injuries, some of these serious, where the cause was not known. There was no record to indicate these people had been involved in an accident or fall. In some cases, the injuries had initially gone unnoticed by the staff. This meant that people did not receive the support they needed, and the provider did not investigate what had happened. The injuries were subject to local safeguarding authority investigation at the time of our inspection.

● In addition to the four incidents above, another incident resulted in a person being harmed as a result of the way in which they were assisted by the staff.

● A further incident in November 2018, resulted in a person falling and not receiving timely assistance from the staff.

● Three other recent incidents where people were harmed included staff failing to notice a person's medical equipment had stopped working, leading to the person losing consciousness and being admitted to hospital, a person becoming dehydrated and malnourished and a person with unexplained weight loss.

● The provider's systems were not operated effectively to ensure the safety of people. The local safeguarding authority were investigating these incidents; however, the provider's own records did not include an analysis of these incidents or guidance about how to protect people from further risk of harm.

● The staff had not always identified that some incidents and accidents could have been the result of physical abuse. Therefore, they did not make the necessary referrals for these incidents to be investigated by a multidisciplinary team. This meant their processes to deal with incidents and suspicions of abuse were not operated effectively and people were not protected from the risk of abuse and improper treatment.

● Whilst some staff had undertaken recent training regarding safeguarding adults, the provider's representatives told us that further training for the staff needed to take place.

The above evidence shows a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● Following receipt of the draft inspection report, the provider supplied us with their analysis of incidents and accidents which had occurred at the service since 1 October 2018. They had identified where systems had not been operated effectively and had learnt from this, making improvements to ensure that systems were being followed.

Assessing risk, safety monitoring and management

● The risks to people's safety had not always been assessed or planned for.

● There were no risk management plans in place for one person who had moved to the service in July 2018. Their initial assessment of need, which had been completed before they moved to the service identified the person was in chronic pain, had multiple medical conditions, swallowing difficulties, was at high risk of falls and needed repositioning every three hours because of the risk of developing pressure ulcers A 'short stay' care plans completed when the person moved to the home also identified the person required a full body hoist to move, had a pressure sore and history of pressure sores, was at risk of aspiration, had a history of hospital acquired pneumonia, was at risk of malnutrition and dehydration and wore continence aids. Whilst there were basic assessments of the risks relating to malnutrition and falling, there were not clear management plans to show how the person could be kept safe. There were no plans for managing the other risks, or to explain how the person could be safely evacuated in an emergency. In October 2018, a visiting health care professional had written that the person should continue to have their food pureed and their fluids thickened. There was no reference to pureed food with the care records written by the staff and no plan to show how the risk of choking would be mitigated.

● The preadmission assessment for a second person who moved to the service in December 2018, showed that they used bedrails, were unable to move independently from their bed to chairs, needed a wheelchair to move around the service, had fragile skin, wore continence pads, used an inhaler, was at high risk of falling and required the use of a hoist. There were no risk management plans in respect of any of these risks, nor was there a plan to indicate the support they would need to evacuate to a place of safety in the event of an emergency. On 9 January 2019, the staff had assessed the person at very high risk of developing pressure sores. There was no plan to show how this risk would be mitigated. On 23 January 2019, a visiting healthcare professional had recorded in the person's notes that the care plans were not detailed enough as there were ''no instructions or guidance about how to give care to [person].''

● The care plan for one person who was at risk of developing pressure sores stated that they should be repositioned every three hours. Records of care did not include evidence of repositioning. The person used a special pressure relieving mattress. Whilst this mattress was checked daily by the staff there was no record to indicate what the right setting for the person was. Therefore, the risks associated with developing pressure sores had not been mitigated.

The above evidence shows a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● People did not always receive their medicines on time or as prescribed. In December 2018, there had been three occasions when the service did not have enough of people's medicines in stock. The provider was

liaising with the pharmacist and GP because they felt this was related to a breakdown of communication about reordering medicines. On the day of our inspection, some people waited four hours to receive their morning medicines. The relative of one person told us that the staff did not always respond with pain relief when this was needed.

● The staff did not always follow guidance when administering PRN (as required medicines). For example, one person was prescribed a PRN sedative ''to be administered when agitated or aggressive.'' We witnessed a member of staff administering this medicine to the person who was calm and sitting in bed. There had been no incidents to indicate this medicine was needed. Records showed that this medicine had been administered seven days in a row. There were no records to indicate a reason for this. Therefore, the person was being sedated by a medicine they did not need at that time. The relative of another person told us that the person slept during the day and they believed this was due to the staff administering sedative medicines.

● Medicines were not always safely stored. The keys to the controlled drugs cabinet in one unit were left in an office drawer. This meant that people without authorisation could access these medicines. The provider addressed this issue during our visit. One person was responsible for administering some of their own medicines. We found that these had not been kept in a secure place in their room, which could have been accessed by others living, working or visiting the service.

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

● Medicines records were accurate and complete. The staff responsible for administering medicines had received training so they knew how to do this safely. There were detailed individual protocols relating to the administration, and reason for, specific medicines, such as pain relief.

Staffing and recruitment

● People told us that there were not enough staff and that they had to wait for care. Some of their comments included, ''There is not enough staff to help me. I have told [the provider] this'', ''When I ask the staff if I can have a shower they tell me they have no time to help me'', ''There is not enough staff and I have to wait'', ''It is fine living here but they [staff] are just so busy'', ''They definitely need more staff'', ''There are never enough staff'', ''I like it here, but I have to wait ages for them [staff] to come and they don't seem to know what they are doing'' and ''If I use my call bell they do not respond quickly.'' Visitors also told us that there were not enough staff. Their comments included, ''It is hard to get things changed as everyone is always too busy'', ''Last week there were no staff available, [my relative] was sitting in bed with just a pad on and had not been shaved, no one came to help'', ''The staff are always telling us they are short staffed and there is not enough of them'' and ''[My relative] always feels rushed by the staff.''

● One person explained that they required the support of two members of staff to use the toilet. They told us, ''There's not enough staff sometimes, I have to wait, I need two staff to hoist me, normally I wait about 45 minutes.''

● The incidents described above including where one person fell and did not receive the assistance they required and where one person's medical equipment failed without staff noticing, indicated that the staff were not effectively deployed o keep people safe and meet their needs.

● During our inspection we noted that one person was still being supported to have their breakfast at 11.55am, less than an hour before their lunch was served. We also observed a person request to use the toilet. They waited 25 minutes before they were supported. The staff apologised the person had to wait but they also told us this was not unusual.

● The provider's representatives explained there was a high number of staff vacancies and they were using over 400 hours of care staff sourced from a recruitment agency and 170 hours of nurses sourced from a recruitment agency each week. This meant that people did not always receive support from the same regular staff who were familiar with their needs.

● Some of the staff told us that there were enough of them to provide care. But other staff commented that it was always ''busy.'' With one member of staff telling us, ''There is enough staff in numbers but it's not well organised, I sometimes see people waiting 40 minutes for attention.'' Another member of staff said, ''There is not always [a staff member] present when people are eating and there really should be.''

The above evidence shows a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider made sure that staff were suitable to work at the service. They carried out thorough recruitment checks on their own employees. These included interviews, information about their employment history, references from previous employers, checks on their identity, eligibility to work in the United Kingdom, professional registrations (for nurses) and information about any criminal records. The provider obtained evidence from the recruitment agencies that these agencies had carried out checks on their staff.

Preventing and controlling infection

● Procedures for preventing and controlling infection were not always followed effectively. Whilst we looked around the environment we found some potential risks, which included a used wet continence pad left on a person's bedroom floor (the person needed staff support to remove this), a used razor left by a hand-wash basin and a bottle containing urine left next to someone's food on a table. We checked these areas again later and found that the staff had addressed these issues.

● Apart from a few areas of the service, we found that the environment was generally clean. We saw cleaning staff working throughout the home. The staff were able to explain to us about good infection control procedures and explained they had received training in this. The staff were provided with gloves and aprons to help prevent the spread of infection and we saw they used and disposed of these appropriately.

● The provider carried out checks on infection control and cleanliness. There were schedules designed to ensure that all areas of the environment were subject to deep cleaning.

Inadequate

Is the service effective?

Our findings

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

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

● The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

● People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

● The provider did not always ensure consent to care and treatment was in line with legislation and good practice.

● One person's care file included details of their Lasting Power of Attorney for care and welfare (LPA) (legally appointed representative). The LPA's name, address and contact number were recorded on the information sheet about the person, but there was no evidence they had been consulted or agreed to any part of this person's planned care. There was a Do Not Attempt Resuscitation (DNAR) form in the person's care notes. This is a document used to show that it would not be in a person's best interests to be resuscitated in the event this was needed to sustain life. There was no evidence of consultation with the LPA regarding this. The form stated the decision had been discussed with the person themselves, however, there was no evidence of this discussion or their agreement to this decision. There was no information to indicate that any best interest process had been followed regarding the decisions about care for this person. The evaluations of the person's care plan in December 2018 and January 2019 stated that the person's next of kin and professionals were involved in 'making complex decisions'. However, there was no record of a next of kin for this person and the form for recording 'key people' had not been completed. There was a named advocate on the person's care notes. However, there were no contact details for this person or evidence of their involvement in supporting the person to make decisions.

● Furthermore, information about the person's mental capacity was contradictory. There was no

assessment in respect of this, there was also no assessments of their cognition, communication and understanding. A pre-admission assessment, undertaken in June 2018, stated that the person had 'normal' comprehension, 'normal' communication and long-term memory. However, the person's care plan written in July 2018 stated they had 'cognitive impairment.' Another part of the person's care plan stated they were able to, 'verbally voice [their] choices.'

● A second person who moved to the service in December 2018, had not had their cognition, mental capacity or mental health assessed. There was no evidence of communication with the person about their care or of their consent to this. The person's care plan of December 2018 stated, ''[Person] is alert but confused'' and ''[Person] would like to get involved [with choices and decisions] but [they] are confused and [relative] is taking decisions over [their] care.'' There was no evidence to state how these judgements had been made. There was no evidence that the person's relative had been involved in making decisions about their care. The person's care file included a DNAR form which was written whilst they were in hospital and had not been reviewed since the person moved to the service. Furthermore, the DNAR did not include any evidence of discussion with the person or their relatives about this decision and simply stated, ''We need to call [person's spouse].'' The section of the care plan dedicated for 'future decisions' (such as decisions around resuscitation) had not been completed.

● We spoke with one person who had the mental capacity to consent to their care. They told us they had never seen their care plan or been asked to consent to this.

● The care plan for another person included evidence of decisions about their care made by an ex-partner. There was no evidence that this representative was legally authorised to make decisions. The care file for a fifth person showed that a relative was an assigned LPA for care and welfare, there was no record to show that they had agreed to the person's care. There was no mental capacity assessment or evidence of best interest decisions in a sixth person's care file. The care plan of a seventh person who had an assigned LPA, had been signed by another relative and not the one who had legal authorisation.

● The provider had failed to ensure that other people had the opportunity to make decisions about whether they wished to be resuscitated, should this be needed. For example, we viewed a care plan which stated a DNAR was in place, although there was no evidence of this, or of the involvement of the person or their family to this. In another person's care file there was a DNAR document which stated the decision was, 'not communicated with the resident, only discussed with the nearest relative.' The care plan stated the person did not have any relatives. A third person's care plan stated they had the mental capacity to make decisions about their care. However, a DNAR for the person stated they lacked capacity and therefore had not been asked for their consent to this. Therefore, information about people's decisions regarding resuscitation was inaccurate and they were at risk of not receiving the care and support they wanted and needed.

The above evidence shows a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● The staff had carried out assessments of people's needs before they moved to the service. These included basic information about their needs, such as their wellbeing and social interests, religion, communication, personal care needs, skin integrity, safety, medical conditions and mental health needs.

Staff support: induction, training, skills and experience

● The staff who cared for people did not always have the skills, experience or training they needed to deliver effective care. For example, on the day of the inspection an agency (temporary) member of staff was assigned the role of reviewing a person's care plan and making sure this reflected their care needs. This agency member of staff told us that they did not know the person and did not know anything about their needs. Therefore, they were unable to deliver effective care or to ensure that care was planned so that others could deliver care effectively. A student who was on placement at the service assisted someone to eat their food. They told us they had not received any training regarding safe support for people at mealtimes, texture modified foods or risk of choking. Therefore, they were not suitably qualified to deliver safe care in this respect.

● The agency staff who were working at the service on the day of our visit told us they were given a ten-minute verbal handover from permanent staff before they started working with people. After this they had been assigned tasks which included administering medicines. This handover of information was not sufficient to ensure they were able to provide safe and effective care, although they said they were aware of emergency fire safety procedures.

● The provider's systems to support staff included holding team meetings and individual supervision sessions for the staff to discuss their work. These did not always happen regularly. Some staff told us they felt supported, whilst others said that they did not get the support they needed. They said that even when they had raised concerns about their work and explained they did not think they could fulfil specific duties, they were not given any additional support. None of the senior staff team at the service had taken part in individual supervision meetings with their line manager since April 2018.

● We were unable to view records of staff training at the inspection visit. We asked for this to be sent to us after the visit. The provider informed us this had been sent, however, we did not receive this. Therefore, we were not able to see if staff had undertaken the training necessary for their roles. The provider told us, during the inspection visit, that some staff training was due. The staff told us that the majority of training they received was via computer on line training. They said that they found this was sometimes difficult to understand and they were not given the opportunities to ask for more support or guidance.

The above evidence shows a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Systems within each unit included records of each person and their primary medical conditions and needs. These were shared with staff working in the unit as a quick reference guide to people's needs. The provider had introduced clinical meetings where a senior manager and nurses discussed individual needs, such as illness, skin deterioration and nursing interventions, so that they were aware of any changes needed to people's care.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● The staff who spoke about the people who they were caring for were able to speak about the various medical needs and interventions they were responsible for. However, care plans did not always clearly record information about these needs.. For example, one person's needs assessment stated they had a number of gastro-intestinal conditions which could be adversely affected by diet. However, there was no further mention of these conditions within the person's care plan and information about how to support the person in relation to these. The assessment also stated the person had some other medical conditions

including depression and pain. There were no care plans in respect of these conditions or the support the person may need.

● People's care files included a section which the healthcare professionals completed. However, this information had not always been translated into the actual care plans.

● There was evidence that people had been referred to dietitians and for specialist healthcare professionals input when they had experienced changes in weight. However, the staff had not always updated care plans with information from these professionals. Whilst the staff regularly weighed people, we saw that they had not always followed individual guidance. For example, one person's care file included a recommendation from the dietitian that the person be weighed weekly. This had not happened, although the person's weight had not declined significantly, and the dietitian was satisfied with the nutritional support they were receiving.

The above evidence shows a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were comprehensive care plans for other people relating to their health conditions. These included monthly evaluations to show how the person's health was being monitored.

● People were supported by a range of healthcare professionals. The local GP surgery visited twice a week to hold surgeries at the service. The staff recorded information about changes in people's health and this was communicated with the doctors. There was also evidence of consultation with other healthcare professionals.

Supporting people to eat and drink enough to maintain a balanced diet

● People using the service mostly liked the food. Some people wanted more variety and did not always feel they had a choice. Some of their comments included, ''The food is ok, but when I have asked for something different they [staff] ignore me'', ''It could be improved a lot, the same things all the time'', ''The best thing is the food'', ''They don't give [person] enough food and when I ask for more they say there isn't any'', ''They meet my dietary requirements'' and ''If I ask for a specific thing they get it for me.''

● People were supported to have enough to eat and drink. The provider employed catering staff who prepared a choice of food for each meal. These choices included an Asian menu. Food was served from heated trolleys in each unit. There were kitchen areas where snacks and hot drinks were made on each unit. People had access to fresh drinks in their bedrooms and communal areas. The staff regularly offered these.

● Some people's nutrition and hydration needs had been assessed and information about these needs formed part of their care plans. For others the assessments were very basic and did not describe risks associated with nutrition.

Adapting service, design, decoration to meet people's needs

● The environment was designed so that people lived in one of four ground floor units. Each unit had one large communal room, other smaller communal areas, an enclosed garden, individual bedrooms with en-suite facilities and adapted bathrooms and showers. The building was equipped with handrails in corridors which were wide, well-lit and hazard free. People had their own slings to use with hoists. Bathrooms and

shower rooms included chairs to enable people to access these.

● There were some attractive features and areas designed to provide a homely environment. However, further adaptions to the environment, in line with best practice guidance for people living with the experience of dementia, would benefit the people who lived there.

Requires Improvement

Is the service caring?

Our findings

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

People did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; equality and diversity; Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

● People were not always well treated or supported, there were not always able to express their views and the staff did not always respect their privacy and dignity.

● Some people using the service described interactions with the staff where their dignity had not been respected. Their comments included, ''The staff keep calling me naughty, but I haven't done anything'', ''When I need help to move the staff rush me'', ''[Some of the staff] are very rude to me, they always say they are too busy and they have no time for me'', ''I think the service would improve if they had nicer staff'' and ''One of the night workers is a bit harsh with me.''

● We witnessed examples where staff did not behave in a caring way. For example, we saw one member of staff take a phone call whilst they were assisting a person with their lunch. The same member of staff used a spoon to scrape food off the person's face rather than wiping this. Whilst they were supporting the person they gave instructions such as, ''open mouth'' rather than speaking with the person in a kind way.

● Some people also gave examples where the staff had not respected their privacy. One person said, ''I feel like I lost all my dignity, respect and privacy when I came here. They stand next to me when I am on the commode.'' Another person told us, ''They [staff] do not knock when they come in my room, and they ignore my requests.''

● We also observed some examples where staff did not respect people's privacy. We overheard two members of staff talking about a person where others could hear them. One member of staff said, ''Well [person] is dirty now we will have to clean [them] and we need to rush.'' In another example, a staff member called across a communal room to a person to ask if they wanted to use the toilet.

● Some people told us that they were not able to make decisions about their care. One person explained that they had to have a regular medical intervention from the nurses. They told us that the nurses often did this wrong leaving them feeling physically uncomfortable. The person was able to communicate verbally and said that they told the nurses when they were doing this wrong and that they were uncomfortable. The person said, ''They do not listen when I tell them, they just ignore me, and this causes significant discomfort and distress.''

● Two visiting relatives spoke about how people were not offered choices or able to make decisions about their care. One visitor said, ''They [staff] have told [my relative] that [they] must go to the day room during the day so they can keep an eye on [them], [person] is not allowed to spend time in [their] room.'' Another visitor commented, ''They do not explain things to [person], so [they] get confused and are not able to make decisions.''

● Therefore, the staff did not always treat people with respect and kindness or in a way that enabled them to be independent and make decisions about their care.

The above evidence shows a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had not proactively taken steps to provide an LGBT+ (Lesbian, Gay, Bisexual and Transgender) friendly environment. The forms used by staff for carrying out initial assessments included finding out about people's religion and cultural background but not about other aspects of their identity. The care plan forms asked whether people ''liked to express their sexuality'' but did not explore this aspect of people's identity in a more holistic way. In most cases the staff had not completed this section or had recorded that people did not wish to discuss this. There had not been any training for the staff to enable them to ask questions about people's identity in an appropriate and inclusive way. We discussed this with the regional support manager. They told us that the provider had recently developed a new diversity procedure and that they would think about ways they could promote a more open culture at the service.

● Notwithstanding the above findings, some people experienced a caring service. We spoke with people who explained they had good relationships with the staff. Their comments included, ''They seem nice from what we can see they are kind and caring'', ''They are reasonably kind and caring, they are better at night'', ''The carers are very nice'', ''They are so caring and attentive, they are sympathetic in the way they look after [person] and also sympathetic to me'' and ''Some of them are kind and caring.''

● We also observed kind and caring practices. These included the staff respecting someone's relationship with their toy doll, by bringing a high chair for the doll to ''eat'' sitting next to the person at lunch time. We saw the staff providing meals in a way which reflected individual choice, such as one person wanting to eat their ice cream out of the wrapper whilst another person wanted theirs in a bowl. One person told us how the staff supported them to go out shopping independently.

● The ethnicity of people using and working at the service was diverse. They had a high number of people who did not speak English as a first language. Except for one person, everyone had staff who spoke in the same first language as them. The deputy manager explained that they used known phrases and pictures to help communicate with the one person who spoke a language no one else did. The menu included Asian meal choices for each meal, because of the high population of people from Asian backgrounds living at the service. We witnessed staff using culturally appropriate terms of respect and endearment when supporting people. The staff supported people to celebrate special festivals and to attend services of worship at the service.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People were not always supported in a way which reflected their needs and preferences.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

● People's care was not always planned in a personalised way to meet their needs, preferences and interests. Three care files we looked at contained only basic 'short stay' care plans for people who were living permanently at the service. One person had lived at the service since June 2018 and another since October 2018. The records showed a short summary of people's needs but did not include a plan to say how these needs would be met. Therefore, there was a risk that they would receive care which was not appropriate and did not meet their needs.

● The staff did not always provide personalised care which met people's needs. The care plan for one person stated that they were supported to eat using a Percutaneous endoscopic gastrostomy (PEG), a system which helps staff to provide nutrition and fluids directly into the person's stomach.. Records for care provided to this person from 3 - 29 January 2019 showed that on eight days there had been no recorded mouth care. There was only one recorded mouth care for each of the other days. The person had experienced a number of oral infections. These could have been as a result of insufficient mouth care.

● The records of care provided to another person who was doubly incontinent, at high risk of developing pressure sores and had a pressure sore, indicated that on five days during January 2019 they had not been supported to wash and on three of these days there was no record that the condition of their skin was checked. There was no recorded mouth care for 11 of the days in January 2019. There were no recorded care interventions for January 2019.

● The care plan for one person stated they would like a shower every other day. Records of care provided showed they had only been supported to have a shower weekly.

● Care plan information had not always been updated when people's needs changed, and this put them at risk of receiving care which was not appropriate. For example, one person's relative told us that the person was at risk when bedrails were in situ. The staff had responded by removing these and lowering the person's bed to reduce the risk of injury from a fall. However, the care plan had not been updated and still referred to the use of bedrails. At the time of the inspection a high proportion of the staff were temporary workers from a staffing agency who were not familiar with people's needs. Inaccurate and out of date records meant that unfamiliar staff did not have the information they needed to care for people.

● There was no information for the staff in the care plan of one person who required a specific intervention. The person told us the staff did not know how to provide this support and often did this wrong.

● External healthcare professionals had recommended using pictures to help one person communicate. The person explained to us that the staff did not use these. There was no reference to using the pictures in the person's care plan.

● We looked at the care plan for one person who used a PEG system. There was generic guidance about the use of this equipment, but there was not a personalised care plan which described how the person's individual needs should be met.

● People did not always have opportunities to participate in social and leisure activities which reflected their needs and preferences. On three of the four units we observed that no structured or group activities took place for the duration of our inspection. Furthermore, most people were not engaged in individual activities. In one unit both the television and music were left on in the same area. People were not given a choice about either. This was reflected in records of social and leisure engagement we viewed.

● An 'activity and interaction' form for one person from July 2018 to January 2019 recorded either no information or the comments, 'no interaction' for the majority of days. The only recorded activities for this person during this time were seven 'room visits' where the person had a 'chat' with staff, (three of these were described as a 'brief chat'), a visit from the barber on one occasion and a note on the person's birthday which said, 'sang happy birthday [person] seemed happy.' Four additional records stated there had been a 'room visit' but that the person was asleep at this time.

● The 'activity and interaction' form for another person from September 2018 – January 2019 also showed 'no interaction' or no record for the majority of the days. The only recorded activities were three 'room visits', one of which was described as 'brief.' There were three additional records which stated the person was visited in their room but was asleep and one other activity which was offered but the record stated they 'refused.'

● The care plan for one person stated they enjoyed yoga and meditation. There was no evidence they had participated in these activities and no record of participation in any activities since 22 December 2018. There was no guidance or information for the staff about how to support the person to participate in the activities of their choice.

● The majority of care plans we viewed did not contain information about people's wishes for care and support at the end of their lives or their preferred arrangements in event of their death. This meant that the staff may not make the right decisions at this time.

The above evidence shows a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● People told us they were aware of the complaints procedure and knew who to speak with if they had a concern. Information about how to make a complaint was shared with people and their representatives and posted to notice boards around the service. The provider kept a record of complaints, and how these had been responded to.

End of life care and support

● Some people were being cared for at the end of their lives. There was evidence the staff had worked with other healthcare professionals, such as the palliative care teams, to ensure people received the right support, including pain relief.

Inadequate

Is the service well-led?

Our findings

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility; Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● At this inspection we found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Our findings indicated that people were not always safe or well cared for. Senior staff at the service told us they and the registered manager had escalated their concerns that there were challenges at the service to the provider. They felt that they had not always received support in response to these concerns, which included multiple staff vacancies and a reliance on agency (temporary) staff.

● The provider's systems for identifying, planning for and mitigating risks had not always been operated effectively.. These included investigating and responding to safeguarding alerts and developing individual risk management plans. People had been placed at risk of harm and had not always received the support and care they needed. For example, a person whose medical equipment failed resulting in them losing consciousness and people with unexplained bruising, fractures and other injuries.

● The provider's systems had not always been operated effectively to monitor and improve the quality of the service, or people's experience of receiving care. The local authorities, who commissioned care at the service had raised serious concerns about the quality of experience and care being provided to some people. During our inspection visit we also identified that people's needs were not always planned for or being met, people did not have access to varied social activities, the provider had not always obtained consent for decisions about care, including the decisions about whether people should be resuscitated or not and there were not always enough suitably trained, experienced and qualified staff deployed to meet people's needs.

● The provider had systems for auditing the service, but these had not always been operated effectively. Their quality assurance systems had failed to identify a deterioration in the quality of the service and the areas for improvement, so the provider could make the necessary improvements and prevent the service from deteriorating further. The senior staff at the service told us that they had not had the time to analyse audits carried out on the individual units. This meant that there was no learning or improvements made from these. Furthermore, audits were not always an accurate reflection of the service. For example, audits of medicines during December 2018 indicated that there were no concerns, however other records showed that there were concerns about medicines stock which resulted in some people not receiving their medicines as planned.

● The provider had not always investigated or learnt from accidents and incidents at the service. We looked at the records of these and found that there was no analysis of 12 accidents/incidents which had happened from September 2018-January 2019. There was some evidence of initial investigation, such as obtaining statements from staff, but not an analysis or indication of what preventative measures had been put in place.

● There were not always accurate or contemporaneous records in respect of people using the service. For example, the record of one person's weight showed a loss of 5kg on one entry. The staff had recorded that there was no change in the person's weight. The following month recorded their weight as having an increase of 6kg and then a further increase of 10kg. Records of care for this person indicated that these were recording errors rather than actual significant fluctuations in weight.

● There was not always a supportive and open culture at the service. Some of the staff told us that they felt they had been blamed for speaking out about their experiences to inspection teams at previous inspections. Two people who we spoke with told us they knew who the registered manager was, they said that they found them supportive. However, the majority of people and their visitors told us that they could not remember meeting the registered manager and did not know who they were.

The above evidence shows a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection visit, we had several discussions with the provider's representatives about their systems and processes and how they were making improvements at the service. They provided us with evidence of the systems they operated to manage incidents and identify areas that needed improving. Following receipt of the draft inspection report, the provider sent us details to show that sometimes these systems had not been followed at a local level, but that they were now addressing this and making sure these were operated effectively.

● The registered manager completed a monthly review of the service which outlined information such as weight loss, pressure sores, medicines reviews, use of antipsychotic medicines, hospital admissions, infections, complaints, safeguarding alerts and accidents. Information about these was shared with the provider's senior managers.

● At the time of the inspection the provider was responding to concerns raised by the local authority and those identified through their own recent audits. Senior managers were working closely with the service, spending time there and working alongside the staff. These included improved clinical risk meetings where the nurses and a senior manager discussed the clinical needs and risks of people on each unit.

● The provider had also taken other proactive steps to help enable the quality of the service to improve. These steps included voluntarily suspending new admissions until improvements could be embedded.

Working in partnership with others

● The regional director told us they had set up fortnightly meetings with the local authority commissioners and provider's own governance team to monitor the progress at the service. They said that they had updated their action plan following feedback at the end of the CQC inspection and would be sharing this plan with CQC and other stakeholders.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider had systems for gathering feedback from people using the service, staff and others. These including sending quality satisfaction surveys. Some people using the service, their visitors and staff spoke positively about their experiences. For example, people mentioned individual staff by name telling us they were kind. Some of the comments from the staff included, ''I love coming to work; even if it is a difficult shift, it is okay because we are doing it for [the people using the service]'' and ''We have a really good team and support each other.''

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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The registered person did not ensure that care and treatment of service users was appropriate, met their needs or reflected their preferences. Regulation 9(1)

The enforcement action we took:

We have imposed conditions on the registration of the provider in carrying on the regulated activities.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The registered person did not ensure that service users were treated with dignity and respect. Regulation 10(1)

The enforcement action we took:

We have imposed conditions on the registration of the provider in carrying on the regulated activities.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The registered person did not always ensure care and treatment of service users was provided with the consent of the relevant person. Regulation 11

The enforcement action we took:

We have imposed conditions on the registration of the provider in carrying on the regulated activities.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
	The registered person did not ensure that care

Treatment of disease, disorder or injury	and treatment was provided in a safe way to service users. Regulation 12(1)

The enforcement action we took:

We have imposed conditions on the registration of the provider in carrying on the regulated activities.

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 registered person did not effectively operate systems and processes to assess, monitor and improve the quality of the service or identify, assess or mitigate risks to service users. Regulation 17(1)

The enforcement action we took:

We have imposed conditions on the registration of the provider in carrying on the regulated activities.

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 registered person did not ensure that sufficient numbers of suitably qualified, competent, skilled experienced persons were deployed to meet the needs of service users. Regulation 18(1)

The enforcement action we took:

We have imposed conditions on the registration of the provider in carrying on the regulated activities.