Bupa Care Homes (CFHCare) Limited

Manor Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**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 but at the time of the inspection one unit, Beech, was closed. Three units are for older people and one unit is for younger adults with physical disabilities. At the time of our inspection 56 people were living at the service. Some of the older people were living with the experience of dementia.

People's experience of using this service and what we found
Some of the provider's care practices did not always ensure people living in the home were safely cared for. Risk management plans were not always followed. Incidents and accidents were not investigated consistently and did not always demonstrate learning outcomes to prevent future incidents. There were not enough staff effectively deployed to meet people's needs and keep them safe. 'When required' medicines protocols did not always describe the person's specific needs so it was clear when to administer these medicines. The provider did not always assess the risk of harm to people who used some paraffin-based creams.

Activity provision was not person centred, therefore people's individual interests were not always met. Our observations during the inspection showed that people were not always treated with dignity and respect or in a person-centred manner.

The provider had systems in place to monitor, manage and improve service delivery and to improve the care and support provided to people but these were not always effective and had not identified issues we found at the inspection. Records regarding incidents and accidents, safeguarding and complaints was not always consistent in demonstrating how they had been investigated, followed through into the care plan and lessons learned recorded and disseminated.

Supervisions, appraisals and training were carried out regularly to develop skills staff required to undertake their roles. However, staff did not always demonstrate they had the skills and knowledge to meet people's needs safely and effectively.

Staff knew how to respond to possible safeguarding concerns to help ensure people's safety. Safe recruitment procedures were in place to ensure only suitable staff were employed to care for people.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People's needs were assessed prior to moving to the home. People were supported to maintain healthier lives and access healthcare services appropriately.

There was a complaints procedure in place and the provider knew how to respond to complaints appropriately. People and staff reported the registered manager was approachable.

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

Rating at last inspection
The last rating for this service was inadequate (published 5 June 2019) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating. We have found evidence that the provider needs to make improvement in all the key questions.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Manor Court Care Centre on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to people being cared for safely, receiving person centred care, people being cared for with dignity, staffing and leadership at this inspection.

After the last inspection when we rated the service inadequate we took enforcement action against the provider. We have imposed a condition on the registration of Manor Court Care Centre that restricts the admission of new people to the home. We have also imposed other conditions on the provider that require them to send monthly reports to the CQC on the staffing arrangements in the home, the state of care planning for new service users and the findings of a number of checks and audits.

As we do not consider that enough improvements have been made at the home, we will continue with the conditions currently imposed on the registration of Manor Court care Centre.

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

Special Measures
The overall rating for this service is 'Requires improvement' and the service will remain in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team included two 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 did not have a manager registered with the Care Quality Commission. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of the inspection, the provider had an experienced manager from within the organisation to manage the home and they were recruiting to the post of registered manager. The regional manager and the quality manager were also based at the service several days per week to provide ongoing leadership and ensure oversight of the home.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with six people who used the service and three relatives about their experience of the care provided. We spoke with the regional manager, the quality manager, three nurses, five care workers and the activities co-ordinator. We also spoke with a visiting healthcare professionals. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included five people's care records and medicines records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has now improved to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to asses and implement risk management plans to reduce the risks to people's safety. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 12.

• The provider had not always effectively assessed and implemented risk management plans. One person who smoked had been prescribed an emollient cream which was flammable. The staff had undertaken a risk assessment about this person smoking, but they had failed to identify the risk around the flammable emollient cream, despite national guidance around the use of flammable emollients. The risk assessment indicated the person did not use this cream, but the skin care plan indicated they did. During the inspection, the person was left outside smoking without supervision. This meant there was a risk to their safety and wellbeing.
• One person's risk management plan around falls stated the person should be supervised when using the garden to reduce the risk of falling. On the day of the inspection, the person was escorted to the garden at 10.30am. They were left alone and unsupervised until 10.55am. This meant staff were not following the falls risk management plan for the person and there was an increased risk of them falling.
• Another person's care plan indicated they should use a standing hoist when going to the toilet. During our inspection, we witnessed the staff assisting this person to use the toilet without the support of a standing hoist. Therefore, they had failed to follow the plan of care set out for this person to reduce the risk of further falls.
• We witnessed a staff member leave the sluice room and go into another room, leaving the door to the sluice room open. There were six cleaning products in the room which could be accessed by people. The failure to assess, identify and mitigate risks in relation to the environment meant people were exposed to the risk of harm.

We found no evidence that people had been harmed however, systems were not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The staff had processes in place to assess risks to people's safety and wellbeing. We saw that assessments looked at people's risk of falling, risks associated with moving and handling, skin integrity, choking, nutrition and hydration and those associated with health needs.
• There were clear plans of action to state how the risks would be mitigated or reduced. These assessments were evaluated and updated each month or when needed. The staff maintained a falls diary which was attached to each person's care plan, so they could quickly identify if people had fallen and the action taken in response to this.
• Reviews of risk management plans were consistent and where required, appropriate referrals were made, for example to the Speech and Language Team (SALT) where a risk of choking has been identified.
• The provider had checks to ensure the environment was safe and well maintained. These included environmental risk assessments, equipment checks, fire risk assessments and a personal emergency evacuation plan (PEEP) for each person. Maintenance and cleaning checks were up to date.

Staffing and recruitment

At our last inspection people told us there were not enough staff on duty and they had to wait for care. Safeguarding incidents at the home indicated staff were not effectively deployed to keep people safe and meet their needs. There were a high number of vacancies and agency staff, which meant people did not always receive support from the same regular staff who were familiar with their needs. This was a breach of regulation 18 (Staffing and Recruitment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 18.

• There were not always enough staff to meet people's needs and keep them safe. One person said there were enough staff but four others said there were not. Comments included, "No, I don't think (there is enough staff)", "There aren't enough but they work well", "In the evening they are short, I think because there are less residents. They work very hard and do whatever you want.", "They're all very nice, some are better than others. But they all have a habit of saying give me two minutes and don't come back or come back 15 minutes later. There aren't enough. They're rushed off their feet" and "Needs more".
• During the inspection, we observed one person in Sycamore unit who had been assessed as requiring supervision whilst using the garden, was left unsupervised for 25 minutes in the garden. In the same unit, there was only one member of staff in the communal area and they were responsible for supervising and caring for seven other people. The other staff on duty in the unit were not in the garden or communal rooms for this period of time, meaning that the one member of staff could not supervise all the people who were in different areas.
• In Larch unit staff were busy. Their interactions with people were very task based and there was no time to spend with people. Staff walked through the lounge on their way to somewhere else, without stopping to talk to people or spend time with them. Tasks were short and interactions minimal.
• In Willow unit one person said staff answering call bells was an issue. We observed call bells taking up to 15 minutes to be answered.
• During the afternoon in Willow unit, there were no visible staff on the unit between 2.05pm and 3pm. Staff were assisting people in bedrooms, leaving four people in the lounge area with no staff supervision. One visitor told us they were looking for staff to help them with their relative but could not find them.
• At 2.30pm on Willow unit, the nurse left the unit for an hour and a half to attend a meeting. They were replaced by the home's receptionist, who told us that they were in charge on the unit. Although the receptionist had previously worked as care staff, it was not appropriate for them to be in charge of a unit when they were not involved in current care plans and communications about people's needs.

The above shows the provider did not have appropriate arrangements to ensure the numbers of staff deployed were adequate to meet peoples' needs and to ensure their safety. This was a continued breach of regulation 18 (Staffing and Recruitment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider used a dependency tool to manage staffing levels so people's needs were met.
• People and staff said the management team were visible and available which meant staff had support and guidance from managers.
• Recruitment procedures were in place and implemented to help ensure only suitable staff were employed to care for people using the service. Since the last inspection the provider has employed more staff to help ensure continuity of care so that agency staff use had reduced.

Using medicines safely

At our last inspection in January 2019 we found that medicines were not always managed safely, and this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 12.

• There were protocols relating to the administration of when required medicines, for example medicines for pain relief. However, we found these protocols did not always describe the person's specific needs. For example, for people who were non-verbal, there were no specific details about the signs or body language the person would present with. Therefore, staff may not be aware of what signs to look for and respond appropriately.

• The provider did not always assess the risk of harm to people who used some paraffin-based creams. This meant people were at risk of harm due to the paraffin based creams being flammable.

We found no evidence that people had been harmed however, medicines had not always been managed safely. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Medicines records were accurate and complete. Staff members responsible for handling medicines had received appropriate training and had been assessed for competency.
• Medicines were stored securely, and only authorised people had access to medicines. Some people at the home self-administered medicines. They securely stored medicines in their own rooms and followed agreed processes to ensure their safety.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to protect people from improper treatment and abuse as evidenced by a number of serious incidents. The provider's systems were not operated effectively as their records did not include an analysis of these incidents or guidance about how to protect people from further risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of this

part of regulation 12.

• Following the inspection, the provider had identified where systems had not been operated effectively and had learnt from this, making improvements to systems and processes to safeguard people from the risk of abuse. Furthermore, they provided CQC with a monthly analysis of incidents and accidents.
• People said they felt safe and the provider had safeguarding adult policies and procedures in place. Staff received safeguarding training to help ensure they had the skills and ability to recognise when people were at risk of being unsafe.

Preventing and controlling infection
• The provider had an infection control policy and we saw a number of checks completed to ensure a clean and safe environment. People said they thought the environment was kept clean.
• Staff had attended training on infection control. One staff member told us their role included teaching others about infection control and monitoring their compliance with the provider's procedures for hand hygiene and infection control.
• Staff wore protective personal equipment such as gloves and aprons to help prevent cross infection.

Learning lessons when things go wrong
• The provider used a particular pharmacy to supply all their medicines. As identified at the previous inspection, we saw issues with the pharmacy continued to affect the care delivered at Manor Court. Staff continued to identify errors with medicines delivered from the pharmacy. This has been a long-standing concern since 2018 and the provider has failed to resolve this with the supplying pharmacy. During our inspection we observed the morning medicines round in Willow unit was still going on at 11am because the nurse who was supposed to be administering medicines was on their own and also trying to contact the pharmacy about problems with the medicines they had delivered.
• Senior managers sought to assure us that these concerns had been taken up at a senior level with the pharmacy and any issues were being closely monitored by the provider. However, our observations identified the provider had not been able to ensure that the pharmacy was making deliveries without errors and this was impacting negatively on the service delivery. Senior managers again reassured us they were in ongoing high level discussion with the pharmacy to resolve the situation.
• We looked at incidents and accidents and found the recording and investigation of these had improved since the last inspection. However, the incident forms did not always have a learning outcome in place. On the first day of the inspection we viewed incident records where it was not clear from the incident records what outcomes and preventative measures were put in place to mitigate risks, although we saw that care plans were generally updated to reflect the incident. On the second day the provider showed us incident and accident records where this was made clear. Therefore, what we identified was that the provider was not consistent in demonstrating learning outcomes to reduce future incidents. We discussed this with the provider who acknowledged the need to be consistent and ensure all learning outcomes were clearly recorded on the incident and accident forms.
• Since the last inspection the provider had put in a number of extra checks and meetings to improve systems and their response when things go wrong. This included a daily meeting for heads of units to update and provide information on lessons learned.
• Managers received a system generated overview of incidents and used it as part of a weekly clinical meeting to feedback on any identified trends and agree on actions to update the care plan.
• A monthly lessons learned report had also been created and was being used as part of a quarterly review to identify trends so these could be addressed and incidents minimised.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has improved to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to provide appropriate training or hold team meetings and supervisions regularly to ensure the staff who cared for people had the skills, experience or training they needed to deliver effective care. This was a breach of regulation 18 (Staffing and recruitment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of this part of regulation 18. However, although staff had training and support, our findings during the inspection showed that the service as a whole was not always effective. We saw examples where staff were not ensuring that risks to people were managed effectively, people's assessed needs, preferences and choices were not always being met and the care provided was task based indicating staff did not always have the required skills to meet people's needs effectively.

• Notwithstanding the above, people using the service were generally satisfied they were supported by staff with the skills and knowledge to effectively deliver care and support. One person said, "All the carers are good, capable and sympathetic." The staff told us that they had a range of useful training. They said that this was an improvement since the last inspection and they had been offered opportunities for a number of face to face training courses. They were able to tell us about these and how they were useful for their role.
• Staff were supported to keep their professional practice and knowledge updated in line with best practice through training, supervisions, annual appraisals and competency testing to ensure they had the appropriate skills to care for people. One staff member told us there was good support from the management team, good teamwork within the team and a number of advance training opportunities in addition to what the provider considered mandatory. They also said there was always a quick response from the manager regarding supporting staff through training whenever there was a need for it.
• The quality manager said they felt it was important that everybody had supervision with the new managers, so they could give praise where it was due and identify areas where people needed more support. Over a hundred supervision had been completed in June and July 2019 to ensure the quality manager made a connection with staff.
• The staff told us they took part in daily handovers of information. They said this gave them the information they needed to understand about people's needs and how to care for them. The management team and unit leaders met daily for a clinical meeting to discuss the whole service. The nurses told us they had regular clinical supervision with the quality assurance manager to discuss the clinical needs of people using the

service and best practice.
• The quality manager completed a walk around of the service three times a day to ensure they were aware of day to day issues.

Staff working with other agencies to provide consistent, effective, timely care

At our last inspection care plans did not always clearly record information about people's needs and guidance from healthcare professionals was not always reflected in the care plans. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of this part of regulation 9.

• The provider worked with other agencies such as the speech and language therapist (SALT), dentist and optician to provide effective care. Care records included information about appointments with health and social care professionals.
• There was evidence of appropriate referrals to other healthcare professionals including referrals to SALT for people with choking risks, the dietician when people experienced weight loss and the diabetic nurse specialist for people with diabetes.

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

At our last inspection the provider did not always ensure consent to care and treatment was in line with legislation and good practice. This included a lack of mental capacity assessments, contradictory information, unclear records around people's legal representatives and failure to ensure people had the opportunity to make decisions about whether they wished to be resuscitated, should this be needed. This was a breach of regulation 11 (Consent to care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 11.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

• People's mental capacity had been assessed and best interests decisions had been made appropriately and as required. Where necessary, the registered manager had made applications for DoLS authorisations

so people's freedom was not unlawfully restricted and a record of when they were required to make new applications was kept.
• Where there were restrictions on people's liberty, the provider had followed appropriate procedures.
• We viewed mental capacity assessments for individual decisions such as the use of bed rails, lap belts and medicines. There was evidence of people having advocates to support them make decisions and give consent.
• Staff had attended training around the MCA and understood the need to obtain consent from people before providing care to them.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• In the files we viewed, people's needs and choices had been assessed before they moved to the service. Assessments included information from the person, their representatives and healthcare professionals. Following the initial assessment, people were observed by the staff so they could identify any specific needs not captured in the assessment. However, no one new had moved to the service since the last inspection, therefore we could not assess whether they had carried out comprehensive assessments since this time.
• The staff regularly reassessed people's care needs and the risks they experienced so they could make changes to the planned care if needed.

Supporting people to eat and drink enough to maintain a balanced diet
• People were supported to maintain good nutrition and care plans recorded any specific needs such as a diabetic care plan. Care plans were regularly reviewed to make sure they were still relevant.
• People generally enjoyed meals and told us, "The food is very good but lacks imagination. We get a lot of the same thing, but what we have is very good", "The food is reasonable. We do have a choice" and "I enjoy the lunch, it's quite good, you get a choice. It's not star but it's good. Suppers are not always great, but you can have a sandwich." One person ordered their food directly from the kitchen. The staff told us food was available for people throughout the day and night and there was a menu of 'night time bites' displayed in the dining areas.
• People were able to make choices from a number of different meals as the menus were displayed on the tables and people were asked in advance. The staff told us that the kitchen provided alternatives if people did not want the main meals. During mealtime service on Larch unit, we noted that staff plated up all the meals before giving these to people. They did not offer choices of main meals, although they did for desserts.
• Where required, people's food and fluid intake were monitored. Although we saw one person's fluid chart indicated they were not being given enough fluids. The staff weighed people. Changes in dietary intake or weight, along with identified nutritional risks, were referred to healthcare professionals. We saw that these professionals had provided guidance for staff which had been included within care plans.

Adapting service, design, decoration to meet people's needs
• Three of the four units at the service were operating at the time of our inspection. Accommodation was provided in three bungalows, each with their own facilities, such as kitchen, dining rooms, accessible bathrooms and single bedrooms. Each unit had an enclosed garden which could be accessed through patio doors.
• The inspection took place on a warm summer day. All units were well ventilated and as windows and doors to the gardens were left open. The communal rooms and corridors were wide and free from hazards. There was enough equipment to meet people's needs, for example hospital style beds, hoists, specialist bathroom equipment and hand rails along corridors.
• The home was nicely decorated, and the staff had made an effort to add homely touches, such as matching table cloths, fresh flowers and a range of ornaments and pictures. However, some areas of the building were difficult to orientate around, and there was little that was sensory or tactile which meant there

was potential for further development in this area in line with best practice guidance on dementia friendly environments.

Supporting people to live healthier lives, access healthcare services and support
• People's healthcare needs had been assessed and planned for. Where they had a specific healthcare need there was an individual care plan, which was regularly evaluated.
• The provider's nurses monitored people's health and wellbeing. They were able to tell us about people's healthcare conditions and any specific requirements or monitoring. The GPs visited the home twice a week and the nurses communicated clearly with them to make sure they visited anyone who was unwell or needed a medical assessment. The staff used written handovers to make sure they communicated changes in people's healthcare needs when there was a shift change.
• There was evidence of regular input from other healthcare professionals. All consultations were recorded and advice from the professionals had been included in care plans and risk assessments. We saw that referrals had been made when people's needs changed or if the staff identified a specific risk. For example, in one case the person's family had requested additional guidance from a healthcare professional. The staff had referred the person and obtained guidance. They had created a new care plan as a result of this and shared the information with the person's family.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

At our last inspection in January 2019 we witnessed examples where staff did not behave in a caring way. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 10.

• One person told us, "Staff are kind, they listen and take on board what you're saying, but if they are rushed, you have to wait so they seem colder because they are busy." We observed some of the time the staff interactions with people were limited and based solely on the task they were performing. For example, we witnessed people being brought plates of food at lunch time. The staff did not offer choices, explain what was on the plate or make comments such as 'enjoy your meal.' When they collected the plates they did not ask about people's enjoyment. In other examples, people asked the staff for items they wanted or needed. The staff went to fetch the items but did not explain they were doing this or pass comment when returning with the item. Another person said, "All the carers do is keep us clean and make sure we have enough to eat. They tend to make sweeping decisions without thinking of people individually."
• One person was supported to move using a hoist. The staff did not explain what they were doing or reassure the person, apart from at the very end of the procedure. Throughout they gave the person instructions such as, 'bend forward' and 'move over that way' without explaining why.
• Most of the time the staff did not sit and talk with people. One member of staff was tasked with supporting a person who was accessing the garden. The staff member stood by the door looking into the building and occasionally looking around at the person. They did not speak with them and when the person returned to the building, the staff member just walked away. In another example, a person asked a member of staff to sit and talk to them. The member of staff said they were busy but would return soon. When the member of staff returned to the room, they ignored the person and began sweeping the floor in another part of the room.

Our observations indicated staff were not always caring in their interactions with people. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Notwithstanding the above, people and relatives expressed satisfaction with the individual way their care was being provided. Comments included, "It's a nice place. All in all, the care day and night is good. They are

all very nice. I can't complain", "I'm quite happy. They make you feel welcome" and "I love it, I like and know all the staff." The compliments book recorded, 'Just want to appreciate you all to provide such a homely environment or positive vibes around the home where residents and staff feel safe and caring' and '…you have given [person] back their confidence and made them feel safe again.'
• We observed staff showing kindness and compassion. One person became distressed and started making a noise. A member of staff went to their side and reassured them. They did their best to find out what was wrong and attempted to comfort them.
• We observed some staff who were good at interacting with people and involving them. For example, in Sycamore unit in the morning the staff engaged people in the communal area. They made sure everyone felt involved and spent time reassuring and checking on each person. They told people what they were doing. For example, ''I am just leaving to get the drinks now but I will be back soon.'' As they went about other tasks, such as sorting out the drinks trolley, they constantly spoke with people making sure people knew they were there. A staff member said, ''I feel happy to give happiness to others'' and ''We always treat them like our mother or father and show them respect.''
• A member of staff was supporting one person who said they used to work in the hospitality industry. They explained how important it was to look the part in their role. The staff member asked the person and their family if it would be alright to buy the person make up. The staff member did this and always made sure the person was wearing their lipstick and had nice hair style which they were happy with each morning.

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

At our last inspection in January 2019 we found that people were not always able to make decisions about their care. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 10.

• There was evidence people were involved in planning their care in terms of care plans recording people's specific preferences but there were no records of people being supported to be involved in reviews or evaluations so they could make decisions about their care.
• One person said, "They do sometimes (ask what I would like to do), but not always." Most people told us they were involved in some element of day to day decisions about their care. For example, how they dressed or where they sat. However, we also observed other instances where people did not have a choice, for example, in one of the units at mealtime we observed people were not offered a choice of meals.

Respecting and promoting people's privacy, dignity and independence

At our last inspection in January 2019, some people using the service described interactions with the staff where their dignity had not been respected. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 10.

• We overheard the staff speaking about people across a busy communal room. They talked about people's needs and what tasks they would be doing for them. These discussions could be overheard by anyone in the room.
• An example of task orientated care, rather than person centred care was observed when we witnessed staff

supporting one person to access the toilet. The bathrooms and toilets had signs stating whether they were vacant or in use. This meant that staff could indicate if the room was in use without having to lock the door in case they needed to support someone. After taking the person to the bathroom, staff left the person alone for privacy. However, they did not change the sign which stated the room was vacant. The staff left the area completely so there was no one to warn others that the room was occupied.

This demonstrated the provider had not always ensured that people were treated with dignity and privacy maintained. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Some people were supported to be independent where they were able. For example, one person laid items on the dining tables for lunch and swept the floors after lunch. People who were able to eat independently were encouraged to do so, and at a pace which suited them. No one was rushed and staff allowed people to complete tasks in their own time. They also respected when people changed their minds. For example, we heard one person asking to be assisted to leave the room but then deciding to stay instead. The staff handled this respectfully and in a non judgemental way.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At our last inspection in January 2019 people's care was not always planned in a personalised way to meet their needs, preferences and interests. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 9.

• Care plans had been rewritten since the last inspection and included a monthly evaluation which sometimes involved the person and their family. However, these were not always personalised. We viewed a care plan for a person in Larch unit who did not speak English and did not see evidence the person was involved in developing their care.
• In some cases, although people's care plans were personalised, staff did not always follow these and used a task orientated approach which meant people did not always have choice and control over their day to day activities.
• We observed in Willow unit that people did always not receive personalised care. There were periods of time up to 30 minutes when no staff were visible in the communal lounge area to monitor people and to check if they needed help and support to meet their needs according to their care plans. For example, one person was calling for assistance to the toilet. As there were no staff in proximity, the person's calls were not acknowledged promptly so they could receive support according to their personalised care plan. After ten minutes of calling, an inspection team member had to find staff to assist the person.

People were not always supported to be involved in planning their care and their wishes and preferences were not always respected. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

At our last inspection in January 2019, people did not always have opportunities to participate in social and leisure activities which reflected their needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 9.

• People were supported to take part in activities but these were not always meaningful. People told us, "I get bored, I'd like it more if I could go out. I've gotten worse since coming here because I don't do anything", "There's an activities leader. I don't really get involved. They mostly do nursery stuff but the quizzes are quite good", "There's not enough to do" and "This morning we played with a ball and we do things outside."
• Activity coordinators were employed to work in each unit. However, on the day of our inspection, two of the activity coordinators were on leave and we did not see that the provider had made alternative arrangements for the provision of activities. On these two units, people were not engaged in social or leisure activities. For the majority of the day the TV or music were left on in communal areas. People were not offered choices about this. Staff did not spend time in the rooms engaging with people or offer them things to do. There were boxes of games, crafts and other items available, but these were not used.

The provider did not ensure that the activities provided to people were always meaningful and reflected people's preferences. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider felt they had put a lot of effort into improving activities since out last inspection. They had employed activity co-ordinators for each of the three units. The lack of activities on the days of the inspection reflected that two of the activity co-ordinators were on leave.
• We observed people being supported in the unit where the activity coordinator was working. This member of staff worked hard to make sure people were involved in activities. They offered people choices and ensured everyone had attention. People who were physically unable to join in with the games being played, were positioned so they could see what was happening and the member of staff involved them through discussions
• There were posters advertising various special events and photographs of events which had taken place on display. Events we saw on the activity board for August 2019 included, the hairdresser visiting, arts and crafts, a coffee afternoon, baking, petting zoo, Punch and Judy puppet show, a trip to the local park, a Brighton trip, church service, afternoon tea, cheese and wine tasting and a photography day.
• Visitors were welcome throughout the day. We saw that visitors felt at ease and part of the community, joining in with activities and speaking with other people on familiar terms, not just the people who they were visiting. Care plans included information about families and other important relationships for each person. The staff told us they liaised with families when they were the named carer for a person, to make sure they felt involved.

End of life care and support

At our last inspection in January 2019, 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 was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of this part of regulation 9.

• At the time of the inspection, no one was receiving end of life care. People's wishes and needs for care at the end of their lives and after death had been discussed with them and their families. Specific cultural needs or individual preferences had been recorded in care plans so the information was available if needed.

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

• The staff did not always demonstrate the skills to communicate effectively with people who were non-verbal. For example, they spoke with them, sometimes asking them questions, but did not use touch, objects of reference or other forms of sensory communication to allow people to understand or communicate back.
• However, care plans included information about people's communication needs and senses. Where people had a visual or hearing impairment this had been documented along with plans to make sure they received the right support.
• We saw one person used a communication book with relevant photos and pictures of things that were meaningful to them including people, food and activities. We also observed examples of people talking with staff in their preferred language.

Improving care quality in response to complaints or concerns
• The provider had procedures in place to respond to complaints. The nature and elements of the complaint were appropriately addressed and responded to. However, the provider did not always use their complaint investigation form which clearly recorded actions and lessons learned. We discussed being consistent so the procedures already in place were used effectively.
• People and their relatives knew who to speak with if they wanted to raise a concern. They told us when they had raised a concerns these had been addressed.

Inadequate

Is the service well-led?

Our findings

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

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

Continuous learning and improving care

At our last inspection in January 2019, 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. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 17.

• Since the last inspection the provider had taken steps to use more effectively systems already in place and had introduced additional checks in response to the findings of the inspection. The reduction in safeguarding alerts and incidents and accidents demonstrated improvements had been made.
• However, it appeared systems were still embedding, and we noted inconsistencies in the way the service was provided to people which meant they were not always protected against the risks of receiving unsafe or inappropriate care and treatment. Record keeping around incidents and accidents, safeguarding and medicines incidents, and complaints was not always consistently maintained to show how these concerns had been investigated, what learning took place, and what lessons were learned, recorded and disseminated to help prevent reoccurrence. This meant we could not be sure lessons learned were implemented to improve service delivery.
• During our inspection, we identified shortfalls that the provider's audits had not. This included risk management plans that were not being implemented and 'as required' medicines protocols not being detailed enough.
• As noted previously in the report, the provider told us they were addressing the dispensing errors made by the supplying pharmacy, but we continued to observe problems during the inspection. Nursing staff were spending lengthy periods of times reviewing medicines administration records and delivered medicines to minimise potential errors. This resulted in nursing staff spending less time with people and other duties.
• At the last inspection in January 2019, the provider was in breach of six regulations relating to person centred care, dignity and respect, consent to care, safe care and treatment, good governance and staffing. At this inspection the provider had met the regulation for consent to care but remained in breach of the other five regulations.
• This was the eighth inspection since May 2015. Six of the inspections were rated requires improvement and one in January 2019 was inadequate. This sustained history of less than good ratings indicates a lack of

leadership in the home.

This showed that systems were not used effectively to monitor service delivery. This was a repeated breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The management team undertook a number of checks and audits. Additionally, there were daily alerts and weekly, monthly and quarterly system generated spreadsheets that recorded areas such as incidents and accidents that have occurred within the service.
• An overall quality metrics report for all managers included nutrition, reviews, health and safety, medicines, bedrail use, deaths, Deprivation of Liberty Safeguards (DoLS), hospital admissions and care plan reviews. This report had an action summary and was one of the reports used to monitor and improve service delivery at the managers' meetings.
• There was also a monthly clinical governance review checklist. A manager walked around each unit every morning, recorded what they saw and used this as the basis of a daily information sharing meeting with senior staff.
• Senior organisational managers had a weekly conference call to discuss learning and development, marketing and recruitment and continuously taking the home forward.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• We found that some of the arrangements around care provision did not always ensure that people received person centred care. For example, the provider did not always provide meaningful activities to meet the needs of the people using the service. Knowing that the activities coordinators were off, no effective arrangements were in place to ensure there were adequate staff to provide social and recreational activities to people. This meant the culture of the service was not always person-centred and inclusive.
• There were many occasions that we observed during the inspection when people did not receive person centred care. Despite action taken by the provider to achieve good outcomes for people and to improve the culture within the home to help provide good quality care to people, there were occasions when people received sub-standard care because the culture within the home was not always positive and person centred.

The fact that the provider had not fully ensured a positive culture and successfully created a person centred environment where people could be cared for according to their needs and preferences meant that this was a further breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff told us the new management team were available to them. Comments included, ''I am happy to work here" and ''It is very good working here, every day I come in with a smile.''

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• People and their relatives knew who to speak with if they had any concerns, so these could be addressed.
• The management team were engaged and open during the inspection indicating they were willing to listen and respond to points raised during the inspection.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• At the time of the inspection, the provider did not have a registered manager in place. However, they had

an experienced manager from within the organisation to manage the home and they were recruiting to the post of registered manager.
• The regional manager and the quality manager were based at the service several days per week to provide ongoing leadership and ensure oversight of the home. They had provided assurances to us that they would remain at the home until good practice was firmly embedded.
• Staff told us there had been a lot of changes and were very positive about the management team. They spoke about improved training but also that the new management team listened, were always visiting the units, knew the staff and people, took on board comments and actually made the changes people asked for. The staff all felt valued and happy. Comments included, ''They are very good, they listen, they look after us, if we want to share something they give us time. Before [managers] never came to the unit. These new managers visit [the units] every day – they know the residents and they know us" and ''We all work together so well. It is very supportive.''
• The registered manager notified us of significant events and safeguarding alerts. 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.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The provider was actively engaging with people using the service and held regular meetings which several people confirmed they had attended. Relatives told us the home had improved and the managers were visible. Comments included, "The whole site has improved a lot. They've started holding management meetings and things have improved. The new manager is very keen and has been speaking to residents and relatives, listening to comments, being open and keen to listen to new ideas" and "There was a time when people seemed to be down, but things have improved a lot over the last few months."
• The provider asked people to complete yearly surveys about their experience of the service. They had a quality improvement plan dated 14 January 2019 and updated 17 July 2019 with actions, an update on actions and the current status colour coded.
• The provider held team meetings to share information and give staff the opportunity to raise any issues.

Working in partnership with others
• We saw evidence the provider worked with other professionals including, the community nurse, dietician, the GP and the local authority to provide effective care that met people's needs.