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The Manor Care Homes

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 16 and 19 September 2017 and was unannounced.

The Manor Care Homes is a care home that provides residential and nursing care for up to 67 people, many of whom are living with dementia. The accommodation is provided over three units, accessible by using the lift and stairs. At the time of our inspection there were 31 people using the service.

The registered manager of the service had left in March 2017. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. An acting care manager, who had previously worked as registered manager in the service, was overseeing the day-to-day management.

We last inspected The Manor Care Homes in March 2017. At this time we found the registered provider was not compliant with the regulations. This was because the provider failed to have effective systems in place to ensure the quality of care was regularly assessed, monitored and improved to ensure people received good care.

At this inspection we found the provider continued to breach the regulations relating to good governance and did not have systems in place to keep people safe. In addition, we found further breaches of regulations at this inspection.

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.

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.

People were supported by staff who did not all have the knowledge and skills to provide safe and appropriate care and support. The provider had systems for ensuring there were adequate numbers of staff but systems were not effective in ensuring staff had the right skills and experience to keep people safe.

People were not always protected from the risk of harm or actual risk because the provider had not consistently notified authorities, including CQC and the local authority, of significant accidents and incidents within the service. This included expected and unexpected deaths of people using the service. This meant authorities were unable to take timely action in order to assure themselves that people protected from the risk of avoidable harm.

The provider did not have established systems or processes in place to enable them to assess, monitor and improve the quality and safety of the service provided. They were unable to demonstrate how they assured themselves that they were providing good care and people were safe in the service.

The provider's safeguarding and staff recruitment procedures helped to protect people from the risk of harm and abuse. The provider had not followed their safeguarding procedure. Although staff raised concerns with managers, concerns had not been escalated to external authorities to ensure action was taken to keep people safe.

Risks to people's health, safety and wellbeing had been assessed and were included in people's care plans. Records included guidance for staff to follow to protect people from the risk of harm.

People were supported to received their prescribed medicines safely.

Experienced staff completed training relevant to their roles. They told us they felt supported to perform their role and responsibilities. Agency staff did not consistently complete induction to enable them to provide effective care. The care manager agreed to review induction training for staff who were new to the service to ensure all staff were able to provide effective care that was personalised.

Staff felt supported by the care manager and the clinical lead and were able to approach them for advice and guidance when they needed to.

Staff ensured people's rights and best interest by working within the principles of the Mental Capacity Act (MCA) 2005. People were supported to make choices and decisions about their care.

People were supported to maintain and improve their health, nutrition and wellbeing. People were supported to access external health professionals when they needed to.

Records to monitor people's nutrition and health were not always completed accurately to demonstrate staff were following guidance from health professionals.

People and relatives had positive relationships with most staff. Some staff demonstrated they were not familiar with people's needs. Staff treated people with kindness, compassion and respect. Staff promoted people's dignity, privacy and rights when they provided care. People and relatives were involved in the development of their care plans.

People's care was reviewed and care plans updated to ensure they reflected people's current needs.

People were supported to pursue their hobbies and interests and people were involved in developing activities in the service. We found at times there was not consistent stimulation to prevent people feeling bored or frustrated.

The provider had a complaints procedures, however people and relatives were not assured that their complaints would be resolved to their satisfactions. This was because although people felt listened to, they felt any improvements made were not sustained.

People, relatives and staff had confidence in the day-to-day management of the service by the care manager. Some people and relatives felt the provider was not in touch with people's needs.

We issued a Notice of Decision to suspend admissions to the service. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not always supported by staff who had the skills and knowledge they needed to keep people safe. People were not protected from the risk of harm because the provider had not notified relevant authorities of accidents and incidents within the service. Staff understood how to raise concerns about people's safety to managers but were not aware of involving external agencies if they felt people remained at risk. People were supported to take their prescribed medicines safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff felt supported in their roles and completed training relevant to their roles. Staff were not consistently supported to complete induction to enable them to provide effective care. Staff followed the guidelines of the Mental Capacity Act 2005 to ensure people's legal rights were respected. Records did not always reflect people's nutritional needs were being met in line with guidance. People were referred to the relevant health care professionals to promote their health and wellbeing.

Is the service caring?

Requires Improvement

The service was always caring.

Staff did not always have the knowledge they needed to meet people's needs. People's privacy and dignity was respected. People and relatives were involved in their care. Staff respected people's choices and lifestyle.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans were regularly reviewed and amended to reflect people's changing needs. People were mostly supported to take part in activities that interested them.. People and relatives were not confident that their concerns and complaints

would be resolved to their satisfaction.

Is the service well-led?

Inadequate

The service was not well-led.

There were no established systems or processes in place to enable the provider to assess, monitor and improve the quality and safety of the service.

The provider had failed to notify us of all significant events and incidents within the service.

The provider was not able to bring about sustainable improvements within the service.

The service was without a registered manager. People, relatives and staff had confidence in the care manager who was responsible for the day-to-day running of the service and felt they were approachable.

The Manor Care Homes

Detailed findings

Background to this inspection

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

This inspection took place on 16 and 19 September 2017 and was unannounced.

The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk of unsafe care. This inspection examined those risks.

The inspection team consisted of four inspectors, a specialist advisor who specialises in nursing care and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert by experience had experience of supporting people who are living with dementia.

We gathered and reviewed information about the service before the inspection, including information from the local authority and previous reports. We spoke with health professionals and the commissioners of the service, responsible for funding some of the people using the service, to gather their views of the care and service. We looked at notifications we have received from the provider. A notification is information about important events which the provider is required to send us by law.

During our inspection visits we spoke with four people, five relatives, two registered nurses, a staff member responsible for activities and nine care staff. We spent time with the care manager and met with the registered provider. We also spoke with a visiting health professional.

We observed care and support in communal areas. We looked at the care records of 13 people who used the

service, medicine administration records, staff training and four staff recruitment records. We also looked at a range of records relating to the running of the service including audits carried out by the acting manager. We looked at the environment including bedrooms, bathrooms and communal areas.

Inadequate

Is the service safe?

Our findings

People and relatives who we spoke with shared mixed views on whether people were safe in the service. One person told us, "They [staff] make you feel more than safe." They explained this was because of the manner and approach of staff while they supported the person and because they had the equipment they needed. Another person told us that although they felt safe, they were concerned about other people at night. They told us this was because, on occasions, night staff did not respond to people's requests for assistance in a timely manner. This upset the person as they could hear people become increasingly agitated. Another person told us, "In the daytime, there are just about enough staff to meet my needs."

A relative who we spoke with told us, "[Family member] is safe here." Another relative expressed concerns about the impact of staff turnover on people's safety.

We asked staff for their views as to whether there were sufficient staff to meet people's needs. Staff who we spoke with told us there were mostly enough staff to keep people safe. One staff member told us, "If I am honest, they could do with one more person [staff] on." They went on to say "Staff often work through their breaks and don't get paid." Other staff felt that there were enough staff to meet people's current needs with extra hours and agency staff providing support to keep staffing levels safe.

Prior to our visit we were told of concerns about staffing levels and the impact this had on people who used the service. Concerns included staff turnover, reliance on agency staff and insufficient staff numbers within individual units in the service.

We checked staffing levels immediately on arrival during both days of our inspection and they appeared adequate. On each occasion there were enough staff on duty to meet people's needs. We reviewed staffing rotas and saw these reflected the staff who were working in the service, although rotas had not been updated to reflect agency staff who were providing cover for staff absence. During our inspection visits we observed that two registered nurses were on duty per shift. One nurse was assigned to the Windsor unit supporting 14 people. They were in turn were supported by four care staff. A second nurse was assigned to the Sovereign unit supporting 12 people, many of whom had complex needs. They were supported by four care staff. This nurse also provided support to four people in the Tudor unit where one care staff member provided support.

The provider had a system for assessing people's needs in order to determine the required staffing numbers to keep people safe. We saw this system, referred to as a dependency tool, had been regularly reviewed.

The care manager told us that although there were some staff vacancies within the service, they tried to minimise the use of agency staff. They told us they monitored the use of agency staff and responded to any concerns about the conduct of agency staff. They were able to show us records where they had responded to agency staff who had not been attentive to people's needs by declining future bookings and escalating concerns through the agencies formal complaints procedure. They told us all agency staff were inducted into the service so they had the skills and knowledge they needed to keep people safe. We saw each unit

had an agency folder which included safeguarding information and a summary of each person's needs.

On the first day of our inspection, we observed an agency member of care staff completing an induction into health and safety within the unit and being shown around the unit by experienced staff. On the second day of our inspection we observed another agency member of care staff who was new to the service. They told us they had just started their shift and had not received any induction into the unit. We saw they were left alone to supervise up to four people within the unit whilst other staff attended to people's needs in their rooms. Supervision was important as some of the people had complex behaviours and required timely intervention from staff to keep them safe. This member of staff was unable to explain how they would intervene if a person became anxious or distressed or what action they would take to protect the person or others from harm. They were not aware of people's names and were unclear of their role. The staff member was left unsupervised for over 40 minutes. This meant people were at risk of harm because the provider had not ensured that staff who did not have the skills and knowledge to keep people safe were appropriately supervised.

We raised this as a concern with the care manager as they had assured us that agency staff worked alongside experienced staff as part of their induction to ensure they supported people safely. This showed that not all agency staff completed induction to provide safe care and was of particular concern given the increasing reliance on agency staff. The care manager told us this was an over sight and the staff member should have received a standard induction. They told us they would ensure all staff who were new to the service undertook induction to provide people with safe care before they started to work at the service.

Prior to our inspection we received concerns about accidents and incidents for people who used the service. These included safeguarding concerns involving actual harm from one person to another and accidents which had resulted in harm to people. The local authority expressed concerns that the provider had not notified them of all reportable accidents and incidents within the service. This included safeguarding (protecting adults from abuse) incidents. This meant they could not take timely action to ensure people were safe and protected from the risk of future harm. These concerns were being investigated at the time of our inspection.

The provider had a system in place to record and monitor accidents and incidents within the service. Staff completed accident and incident forms and these were in turn reviewed by senior staff. There was evidence that these records had been analysed each month to identify the reason for the accident/incident. For example, where a person had experienced a fall, the incident had been analysed to identify why the person had fallen, who had been informed and any changes that were required to the care plan.

However, records did not show how this information was used to identify any trends or patterns to incidents. We found a large proportion of records involved people sustaining bruises and injuries from falls and incidents of behaviours that challenge. These had resulted in people being exposed to avoidable harm. Records did not show that these patterns had been identified and used to make improvements within the service to keep people safe. There were many incidents between April 2017 and July 2017 that had not been notified to the Care Quality Commission. A number of people of people had been at risk from actual or potential harm since our last inspection. The provider had not followed their safeguarding procedures by ensuring relevant authorities were informed so that appropriate action could be taken to prevent people being exposed to harm in future. The provider had not ensured that measures were in place to protect people from the risk of harm.

The provider is required by law to notify us of significant events and incidents within the service that affect the health, safety and welfare of people. This meant that we could not take any timely follow up action to

ensure the provider had taken reasonable measures to keep people safe.

The provider acknowledged that these notifications had not been sent to us during this time. They advised that the care manager would be ensuring all future notifications would be made in line with the provider's legal responsibilities.

Following our inspection visit, the acting manager notified us of an incident where a person had experience serious harm as a result of insufficient staff deployed within the service. The person had been left unsupervised within the service. This incident demonstrated that the provider had not implemented adequate systems or processes to ensure people were safe. This incident was being investigated by relevant authorities.

We looked at how the provider protected people and kept them safe from the risk of abuse. The provider's safeguarding (protecting people from abuse) policy and procedure had guidance for staff as to what they should do if they were concerned about the welfare of people who used the service. Staff demonstrated that they knew the signs of abuse and understood the procedure for reporting safeguarding concerns to the care manager or provider. However, staff were not always aware of their responsibilities in raising concerns with external agencies if they felt the provider was not taking appropriate action to protect people from the risk of harm. The provider had demonstrated they had not followed their safeguarding procedures by failing to notify authorities to ensure action was taken to protect people from harm.

The above evidence demonstrates that the provider did not take appropriate action to protect people from harm and staff did not consistently have the skills and knowledge to keep people safe from avoidable harm or the risk of harm. These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care records showed risk assessments were completed and reviewed to reflect people's current needs. Those related to people at risk of falling when walking or moving around, people who needed support to move safely, people with behaviours that could challenge and people at risk of developing pressure sores. Risk assessments provided clear guidance for staff on the nature of potential risks, details of any equipment to be used and measures staff needed to take to reduce the risk of harm for the person. For example, one person was assessed as being at high risk from falls. Their risk assessment detailed equipment to be used. This included the type of hoist, the size of sling and a specialist chair. We observed staff support the person in communal area and saw they were using the correct equipment and supported the person to move safely. However we remained concerned as staff were not always provided with time to look at people's risk assessments before assisting people with care. This meant that there was a risk that staff were not aware of the measures needed to reduce the risk of harm for people and therefore did not support people safely.

Throughout our inspection we saw examples of staff supporting people to move around safely. These included staff supporting people to sit down safely in armchairs. We saw staff guide people to use the arms of the chairs to position themselves safely and prompted them to ensure they were sat back to prevent them falling out of the chair. We also saw staff support people to use their footplates on wheelchairs when moving around the building to ensure they did not injure their hands when self propelling or feet. These examples demonstrated that staff were aware of the measures required to protect people from harm whilst moving around the service.

People's safety was supported by the provider's recruitment practices. Staff recruitment records we looked at showed that relevant checks had been completed before staff worked unsupervised. Checks included

evidence of previous employment, proof of identity and a check with the Disclosure and Barring Service (DBS). DBS checks help employers to make safer recruitment decisions and ensure that staff employed are of good character.

The provider's medicines management procedure was up to date. Staff told us some people had their medicines disguised in food and drink, otherwise known as covert administration. We observed a nurse administering medicines during the morning and lunchtime. We saw two people's medicines was given in a drink. The nurse stayed with both people to ensure all the medication/drink had been consumed. We looked at these people's care plans and saw the plan included a personalised medicines plan detailing why the covert medicine was in place, the use of it, who was to administer it and how it was to be administered. Records showed covert medicines had been authorised by and signed by the GP. These plans had been reviewed to ensure the use of covert medicines was still required in the person's best interests.

We saw the nurse administering medicines followed safe procedures. They explained to people what the medicine was for and gave them time to take their medicines. Where people were prescribed medicines as and when required, (PRN) the nurse consulted with people as to whether these medicines were needed. For example, we saw she asked people if they were in pain and required pain relief medicines. Records showed these medicines were supported by a protocol which informed staff why the medicine was prescribed and how it should be used.

Where three people declined their medicines, the nurse showed compassion and understanding. She told us that people did decline their medicines on occasions and that she would give them time and return for a second attempt. We saw that people accepted their medicines when the nurse offered these a while later. This meant that people were provided with opportunities to express their right to accept or decline their medicines.

Medicines were stored safely. Temperatures of storage areas, including refrigerated medicines, were checked daily, recorded and shown to be within recommended temperature range to maintain the condition of the medicines. We looked at a sample of medicine records including entries in controlled drugs registers. These had been completed accurately and correctly. Front sheets in the medicine administration folder contained photographs to identify people. This meant staff who were new to the service could identify people and reduced the risk of medicine errors.

Staff we spoke with told us they had been trained to give medicines and were only able to do so after being assessed as competent by a senior staff member. This was confirmed in training records.

Requires Improvement

Is the service effective?

Our findings

People who we spoke with told us they were happy with their care and were able to identify individual staff with whom they had developed positive relationships. Relatives who we spoke with told us they were mostly happy with staff. One relative told us, "I visit at different times of the day and I am very pleased with [Family member] care." Another relative said, "Staff work very hard." A third relative praised the staff for supporting their family member to maintain good health and well-being. They told us this had also been identified when a person recently attended a hospital appointment which impressed the relatives. They felt this reflected that their family member was receiving good care.

Staff told us they received the training they needed to provide effective care. One staff member told us, "The training given is excellent." Another staff member told us they had received a good induction which made them happy and confident in their role. A registered nurse told us that the clinical lead assessed the competency of the registered nurses to ensure they had the clinical knowledge they needed in their roles. Staff told us they were encouraged to keep their training up to date through completing on-line training.

Training records we saw showed permanent staff who were new to the service had completed induction and received essential training, such as manual handling, health and safety and safeguarding. This was in addition to courses specific to people's needs, for instance, dementia awareness and pressure care. Updated training was available to all staff through on-line courses.

Permanent staff we spoke with demonstrated they were knowledgeable about people's specific needs. For example, we asked staff about their awareness of the needs of people living with dementia. They were able to describe what a dementia illness was, the different types of dementia and how they could support individual people in times of distress. This showed that permanent staff were able to apply their training to provide effective care.

The care manager told us agency staff were provided with an induction into the service. This included essential information, such as health and safety and safeguarding, in addition to a summary of each person's needs. They also worked alongside experienced staff to get to know people. There was a separate induction folder for each individual unit. The care manager told us they would ensure all agency staff received an effective induction to the service. However, we saw this was not applied consistently. An agency member of staff who was new to the service was left to support people unsupervised. They had not received any induction into the service and were not aware of people's needs. They were not able to provide effective or safe care.

Following our inspection, a person was exposed to avoidable harm and as a sustained serious injuries. The care manager told us they were investigating the incident which involved staff making a decision to leave the person unsupervised during the night. This showed that not all staff were knowledgeable about people's needs and people did not receive consistently effective care to keep them safe.

Staff told us they felt well supported within their roles. This was as a result of the supervision and support

from the care manager and clinical lead. The care manager showed us a schedule of supervision which provided protected time for staff to meet with their line manager to review their roles and development needs. Although formal supervision sessions had fallen behind, the schedule enabled managers to build in this time as part of the day to ensure staff received the support they needed in their roles.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked to see if staff had an understanding of the MCA and applied the principles in practice. We found that staff received training and they understood and followed the principles of the MCA to obtain people's consent or appropriate authorisation for their care.

We saw staff supported people to make choices and asked for their consent before they provided care whenever people were able to give this. For example, where one person used non-verbal communication, staff waited for the person to indicate their consent to care by the person using thumbs up or thumbs down as a response. Staff consulted with people as to how they wanted to spend their time and where they wanted to be. Where one person was consistently adamant that they wanted to remain in a corridor, staff respected this choice and spent time with the person to ensure they did not become isolated and they had everything they needed.

People's care plans showed an assessment of their mental capacity and a record of any decisions about people's care and treatment when these had been made in their best interests. Records showed staff had consulted with people's relatives and relevant health professionals to support people's rights and best interests. For example, where relatives were legally appointed powers of attorney which enabled them to act and make decisions on people's behalf. Where people had DNACPR plans for care and treatment in the event of a sudden collapse, these were signed and dated and, where appropriate, kept under review to ensure records reflected people's current wishes.

Some people's freedom was being restricted in a way that was necessary to keep them safe, known as DoLS. For example, when people were not able to independently choose whether or not to live at the service or required constant supervision. We found the provider had followed the law by submitting relevant applications. Where formal authorisations had been issued, all relevant documentation was in place and care plans had been updated to reflect the authorisation. We saw the conditions of the authorisation being granted were met. Authorisations were kept under review and, where necessary, applications made prior to them expiring. This meant people were protected from the risk of having their liberty unlawfully restricted.

People were supported to maintain good nutrition. People were positive about the food provided and said they enjoyed their meals. One person told us, "The food is good, there isn't enough of it." We observed people were offered and provided with second helpings during mealtimes. One relative commented that they felt their family member was eating well since moving to the service as their weight had improved and was now stable. We saw that people were provided with a choice of hot or cold drinks at all times and staff checked whether people had sufficient to drink. Staff also offered people snacks with their mid-morning and mid-afternoon drinks.

Some people had difficulty eating and drinking because of their health condition. Where this occurred, staff ensured people were provided with the support they needed and the correct consistency of food. For example, if people had difficulty swallowing and needed pureed or fork mash-able food. We observed staff supported people to eat at their pace and provided encouragement and conversation during the meal. Staff checked that people were happy with their meals, offered a choice from the daily menu and provided alternatives where required. People were provided with meals in line with their cultural preferences, such as Asian and West Indian food. This helped enhance people's mealtime experience.

Records showed that people's nutritional needs, body weight and dietary requirements were assessed before they received care and regularly reviewed. Where staff had concerns about people's food or fluid intake, they had been referred to their GP and, if necessary, the Speech and Language Team (SALT).

Records used to monitor if people were receiving food and drink in line with dietary guidance varied. For example, one person required potassium rich foods including two bananas a day. Records showed that the person had one banana most days and no evidence that the person was regularly receiving potassium rich foods. Another person required fortified meals to help reduce the risk of weight loss. Records showed that, over a six-day period, the person receiving fortified meals twice a day for three days and once a day for another day. There were two days where there was no record that the person had received their fortified meals.

Where people required their fluid intake to be monitored, records were not always completed consistently or accurately. For example, one person's records showed they consumed 200mls of fluid each time they had a drink. However, we observed that although drinks were regularly provided for the person, they did not always consume the full amount as they tended to walk around the service and leave the drink unattended for periods of time. The drink was cleared away periodically. This showed that records did not accurately reflect the fluid intake for the person. Another person's fluid intake was recorded each day. However, records did not include the daily target amount of fluid the person should be having. Therefore it was not possible to determine from records if the person was having sufficient fluids to prevent de-hydration. This showed that although there had been some improvements in the recording of people's nutritional and dietary needs since our last inspection, there remained inconsistency in the accuracy of these records. Records did not demonstrate staff had understood and were following guidance from health professionals.

People were supported to attend health appointments and staff arranged for a range of health professionals to visit people regularly. These included routine appointments, such as dentists and chiropodists and specialist appointments with consultants and mental health teams. People's care records showed they received health care support and care plans had been reviewed and updated to include guidance. For example, where people showed complex behaviours, behaviour management strategies to guide staff on appropriate interventions were included in care plans. This showed people were supported to maintain their health and wellbeing.

During our inspection we spoke with a visiting health professional who was supporting staff to manage and respond to the needs of a person whose behaviours could challenge. They told us they had observed positive interactions between the person and staff. They also told us staff were knowledgeable about the needs of people they supported, sought and followed the guidance provided to meet people's needs.

Requires Improvement

Is the service caring?

Our findings

People and relatives spoke positively about experienced staff but had concerns about some agency staff. People's comments included, "The staff are very good as they know you well and we have a good laugh together, "They [staff] look after me, I know that they care," and "They [staff] care." One person told us "Most of them [staff] are good." They went on to explain that they had had concerns regarding one member of staff which they had raised with the manager and this had since been resolved. Another person expressed concerns about agency staff. They told us, "The agency staff do not know what they are doing. Every time they come in, I have to tell them what to do. I have my way of doing things and they [agency staff] don't like to do it."

A relative told us, "You cannot fault the care of the staff. [Family member] is always well dressed, showered and clean. They [staff] care so well for him." Another relative told us they were happy with staff interactions with their family member and felt these reflected the person's care plan. A third relative told us, "The staff are nice."

We found that agency staff were not knowledgeable about people's preferences and were not consistently clear as how people preferred their care to be provided. This was because agency staff had not always been supported to understand people's history, needs and wishes. We saw one person attempted to communicate with a staff member. They were asking for the staff member to open a closed door which was causing them some distress. The staff member was not able to understand what the person wanted, thereby increasing their distress. The staff member was eventually supported by another staff member to understand what the person wanted and open the door. The person immediately calmed and said, "That's right." This showed that all staff were not familiar with people's needs.

Staff spoke about enjoying their jobs and working as a team to meet people's needs. One staff member told us, "Staff here would do anything for our residents and for one another." Another staff member said, "I just love working here. The residents are our absolute priority." A third staff member described how they enjoyed working with people and gained satisfaction from knowing they had made people happy and 'done a good job'.

Staff demonstrated mostly caring relationships with people. We observed staff were attentive to people's needs and took time to talk with people and ask if they needed anything. For example, we saw one staff member sitting outside with a person talking about different plants and flowers. We saw another staff member holding a person's hand and sharing conversation and humour to provide reassurance to the person.

Staff respected people's dignity, privacy and choice when they provided care. Throughout the inspection we saw staff were courteous, polite and consistently promoted people's choices. For example, people's choices about their meals and drinks, where, who and how they wished to spend their time. Staff we spoke with showed they understood the importance of ensuring people's dignity. They were able to demonstrate how they did this. For example, adjusting people's clothing to ensure their dignity was maintained, providing

personal care discreetly and ensuring people were clean and suitably dressed.

Staff supported people to maintain their independence. We saw staff prompting people to make drinks and assist with household tasks such laying and clearing the table for mealtimes. People were free to move around the service as they liked with support from staff where required.

People were supported to maintain contact with family and friends who were important to them. Relatives told us staff made them feel welcome and they could visit at any time to suit the person receiving care. People's relatives also said they were appropriately informed and involved in people's care. This included care review meetings. One relative told us, "I appreciate how they [staff] include me in [name of family member] care." Another relative told us they had full involvement in their family member's care plan.

Staff respected people's diversity and were aware of specific cultural needs. Some staff were able to speak in people's first language which was not English. We saw people responded positively to this and shared banter and humour together. One person told us they were not confident to speak in English and appreciated staff communicating with them in the first language as this gave them confidence. Staff told us the person requested them to be present for all medical appointment to translate for them and these staff made sure they were always available. This helped to ensure people were involved in their care.

Requires Improvement

Is the service responsive?

Our findings

People told us they were encouraged to make decisions about how they spent their time and who they spent it with. They told us there were activities that they could choose to take part it or they could spend time in one of the lounges or their own room. One person told us, "I can choose what time I get up and go to bed." Another person told us, "I can choose to go to bed when I want." They told us they were free to choose how they spent their time. We saw the person was able to leave the service to attend personal activities and medical appointments when they wished. Where people requested support to move from one area to another, for example from the lounge to their room for a rest, we saw staff provided this support in a timely manner.

A relative we spoke with told us how staff had responded to a change in their family member's needs which had resulted in them showing an increase in behaviours that could challenge. They told us staff had suggested moving the person to a higher dependency unit to enable them to have a bigger room and more intense staff interaction. The relative told us as a result, their family member "Had more good days than bad," was more settled and appeared to have benefited from this response.

People had an assessment of their needs when they moved to the service. People and their relatives were also asked to complete a 'My life story' document which detailed the person's life history, people who were important to them and wishes and preferences. Information from the assessment and the life story document had been used to develop the care plan. For example, a person identified it was important to them to maintain a smart appearance each day, including clean clothes. Staff had supported the person to maintain a good standard of personal care and that they were dressed in smart clothes in line with their preferences. Another person's care plan identified that they liked music. We saw staff offered to put music on in line with person's preferences during our inspection visit. The person responded positively to this.

Care plans had been updated to reflect changes in people's needs. For example, where a person became distressed or anxious, their care plan had been updated in line with guidance from mental health professionals. This provided clear information for staff on suggested interventions and approaches to support the person to reduce their anxiety. Experienced staff told us they had read people's care plans and that senior staff were always helpful if anything needed explaining or advice was needed. This meant that people received care from experienced staff that was personalised and met their needs.

Care plans were not always signed by people and records did not reflect people's involvement in the review of their care. When we spoke with relatives, they confirmed that they were kept informed by staff and involved in people's care. They also confirmed that they were regularly invited to participate in review meetings about their family member's care and were kept informed of any changes.

People's care plans included information about their likes, for instance what time they liked to get up and how they liked their personal care to be provided. Records showed their wishes had been taken account in the care provided. Staff knew what people liked, for example staff offered a person their favourite drink. Staff were able to tell us about people's routines and preferences and this mostly matched what we saw in their

care records, although some records were more detailed than others. This meant people received care in line with their choices and preferences.

During the first day of our inspection we saw limited activities provided for people. Staff told us this was because the staff members responsible for activities, referred to as activity co-ordinators, did not work over weekends as a rule. The activities that we did see included colouring, music and light exercise. One person we spoke with told us they would like to go outside as the weather was nice but they were not able as there were only enough staff to supervise in the unit.

On the second day of our inspection we spoke with an activity co-ordinator. They were supporting people in individual activities, such as colouring, reading and embroidery. They worked with people in all units to prepare ingredients and put together home-made pizzas. We saw people enjoyed this activity, with many people reminiscing about the cooking they did when they lived independently. The activity co-ordinator told us the pizzas would be cooked later in the day and served for the evening meal, which people were looking forward to. We saw another person was encouraged to support staff by folding table cloths. They told us they were proud of their attempt as they thought they had done better than the staff member supporting them.

We saw a range of tactile pictures on the walls of communal areas. People told us they had worked with the activity co-ordinator to develop ideas for the pictures and contribute to making them through using a range of collage materials. One person told us some of the pictures reflected their cultural beliefs and proudly showed us a current picture which they were looking forward to working on. The activity co-ordinator told us that bread making, art games, skittles, quizzes and local walks were all offered at the service. They told us a boat trip had been planned. One staff member told us, "People engage well with activities and are keen to join in. It's all based on what people want."

We discussed the lack of stimulation for people at weekends with the acting manager. They told us they were aware of this and were working with staff to identify creative and innovative ways to stimulate people in the absence of activity co-ordinators.

There was a policy in place for complaints and we saw that if complaints were received there was a set process to follow. This meant complaints were investigated and responded to within a set time period. People and relatives who we spoke with shared mixed views on the response to concerns they had raised. Two people told us they were confident to raise concerns with the manager but had not had any need to. A third person told us they had raised concerns but had received a "mixed response" from the service as a result. This was because they felt that although their concerns had been listened to; improvements were not always made or sustained as a result. A relative showed us an item of clothing that was not their family member's but had been put in their room. They told us they had raised concerns about items of clothing going missing before but improvements never seemed to last. This meant that people could not be assured that appropriate action would be implemented to resolve their concerns.

The acting manager told us that they had been unable to locate records of previous complaints. They had therefore started a new file from August 2017. We saw that there was one complaint on file which had been made by the acting manager to an agency provider following concerns about agency staff.

Inadequate

Is the service well-led?

Our findings

At our last inspection of the service in March 2017, we found that effective systems were not in place to ensure the quality of care was regularly assessed, monitored and improved to ensure people received good care. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that required improvements had not been made.

We asked to see the provider's records of quality assurance within the service. The acting manager told us that no quality assurance had been carried out in the service between April - July 2017. This was of particular concern as prior to our inspection we had received numerous concerns regarding people's safety and wellbeing in the service between these dates. Records showed that the provider had not acted openly or transparently in reporting safeguarding incidents to relevant authorities to ensure people were protected from harm.

The provider had not ensured audits and checks were undertaken to offer assurance staff supported people safely and records reflected people were receiving care to meet their needs. The provider had not identified that trends and patterns from accidents and incidents within the service had been identified, appropriate notifications made and appropriate action taken to keep people safe. The provider had not ensured effective systems were in place to assure themselves that people were receiving good care.

Previous inspections dating back to 2015 have found a variety of shortfalls in the service and provision of care. During that time we have carried out further inspections to determine if actions to improve the service and care had been made. We found that any changes had not always resulted in sustained improvements. Where improvements had been made, we found further or different changes were required. This showed that the provider was unable to make sustainable improvements to the service to provide good care.

We spoke with the local authority commissioners, responsible for funding some of the people who used the service. They told us they had significant concerns regarding the safety and well-being of people and as such had issued an action plan requiring the provider to take urgent action to make improvements. They told us the provider had not made the required improvements within timescales and therefore the local authority would be taking further action.

This evidence demonstrates breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider did not have established systems or processes in place to enable them to assess, monitor and improve the quality and safety of the service provided in the carrying on of the regulated activity.

Registered persons are required to notify CQC of certain changes, events and incidents at the service, including allegations of abuse, serious injuries, expected and unexpected deaths for people who used the service. Our records showed that CQC was not notified of 10 deaths within the service between April - August 2017. When we reviewed accident and incident records within the service, it was clear that there had been many incidents which the registered person had failed to notify us about. These included people

experienced actual harm from another person and accidents that had resulted in serious injury. This meant that CQC had not been made aware of untoward incidents in the service even though the registered person has a duty to do this.

The registered provider told us they were aware that significant incidents and events in the service had not been notified to us. They told us they had assumed that the previous acting manager had made the appropriate notifications and had not checked that this had been done. This showed that the provider was not monitoring systems and processes to ensure people received safe care.

This evidence demonstrates a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. The registered provider did not notify us of all incidents that affected the health, safety and welfare of people using the service.

People and relatives told us they were happy with the day-to-day management of the service but expressed concerns regarding the overall management. One person told us, "He [care manager] is the boss of the place. He is nice but firm." However another person we spoke with told us the problems were with the provider who did not always work in an open and transparent way. They told us, "They [provider] have changed as you [CQC] are here. He has given us all magazines. He even gave one to a person who cannot see. We told them but they didn't believe us until a staff member said they can't read the magazine." Our inspection team observed this was the case.

A relative told us they would recommend the service to other people because they had been impressed with how staff had responded to a change in their family member's needs. Another relative told us, "The [higher] level management are the issue and how they communicate."

A high number of staff had left employment and we were told this was because staff morale was low and there was a lack of leadership and guidance within the service prior to the appointment of the care manager. However, staff spoke highly of the care manager and acting clinical lead as being supportive and inspirational. Comments included, "[Care manager and clinical lead] are always available to offer staff support and guidance," and "[Care manager} will do anything he can to support us, he is marvellous."

The service did not have a registered manager in post since April 2017. The provider had appointed a new manager who had left the service prior to our inspection. There was an acting care manager in post who had previously worked as registered manager in the service. They told us they were supporting the provider and staff whilst the provider recruited to the post of registered manager. The care manager was supported by an acting clinical lead who supervised and monitored the registered nurses and clinical care within the service. This meant people had a clear line of leadership and knew who to approach for advice and guidance.

The care manager had introduced a 'team brief' each morning. This involved heads of units meeting with the care manager to discuss and review each person's care needs and identify appropriate responses if someone's needs changed. We saw all staff were well informed and provided detailed information to the care manager to assure him people were receiving care as detailed in their care plan. The clinical lead provided updates to registered nurses. For example, she alerted them to pending revised practices in monitoring people who may be at risk of urinary infections. This showed that clinical staff were provided with information to keep them updated of best practice.

The care manager told us they had implemented a new quality assurance process. The first audits and checks had been carried out in August 2017. We saw these checks were comprehensive and detailed and involved observations in communal areas and checks on a range of care and health and safety records. We

sampled four action points from audits and found that improvements identified had been followed up and people's care plans had been updated accordingly.

The registered provider told us they were in the process of engaging consultants to support them to develop action plans that identified improvements that were required in the service.

People, relatives and staff were attending a range of meetings at the time of our inspection. These had been arranged by the provider and by the local authority to discuss actions and choices for people using the service. This helped to provide people and their relatives with the information they needed to understand developments in the service, what this meant for them and be supported to decide on how best to meet their care needs.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to report incidents that affected the health, safety and welfare of people using the service to relevant external authorities/bodies. The provider failed to ensure staff had the skills and knowledge they needed to provide safe care.

The enforcement action we took:

Notice of Decision to suspend admissions to the service