Burlington Care (Yorkshire) Limited

Maple Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 8 and 13 August 2018 and was unannounced. The service registered with the Care Quality Commission (CQC) in November 2017 as a new service. This is its first rated inspection.

Maple Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection.

Maple Court provides nursing and personal care for up to 64 people. The service supports older people who may be living with dementia. At the time of our inspection there were 39 people who used the service.

There was a manager in post who registered with CQC in November 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.

Insufficient staffing levels were impacting on all aspects of the service and the system used to determine the numbers of staff required and deploy them around the service was not robust. The regional manager for the service took action on the second day of our inspection to make some improvements to this aspect of the service.

Staff did not receive appropriate training to enable them to effectively and efficiently carry out their job roles and duties. Meetings with staff to discuss work performance (supervisions) were in the form of individual and group settings. However, these did not always cover individual performance or offer staff an opportunity to discuss any work issues they may have. There was a lack of effective communication between the care staff, nurses and the management team. This meant people's health and well-being was at risk of harm.

The management of medicines was not robust and meant medicines were not administered to people as prescribed by their GP. This put people at risk of harm.

The quality assurance system within the service was not being operated effectively. Audits completed by the provider and the registered manager showed several recognised concerns with regard to documentation and people's health and well-being. However, insufficient action had been taken to mitigate these known risks.

The quality of the record keeping varied and some care records we looked at were not personalised and were inconsistent or incomplete. This meant staff did not have an up to date record of people's care and treatment. Agency staff were used frequently in the service, but they and the permanent staff found it time consuming to access and read the electronic care records. Due to work pressures and the lack of organisation in the care service, care staff told us they did not always have the time to read the care records

meaning they lacked knowledge of people's care and support needs.

The assessment, monitoring and mitigation of risk towards people who used the service regarding hydration, nutrition, weight loss and pressure care was not robust. People had lost weight and their records of nutritional intake and care were not being completed or updated in respect of their changing needs.

People's privacy and dignity was not consistently respected. People were left waiting until late in the morning to get out of bed. Two people's anxious and distressed behaviours were not being met which meant they were left lying on the floor until staff had time to attend to them.

We found breaches of Regulations 10, 12, 14, 17 and 18 during this inspection in relation to dignity and respect, safe care and treatment, meeting nutritional and hydration needs, good governance and staffing. You can see what action we told the provider to take at the back of this report.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People could talk to health care professionals about their care and treatment and see a GP when they needed to. They received care and treatment when necessary from external health care professionals such as the district nursing team.

People had access to community facilities and a range of activities provided in the service. People and relatives knew how to make a complaint and eight out of the ten relatives/visitors who spoke with us were happy with the way any issues they had raised had been dealt with.

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.

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 consistently safe.

Insufficient staffing levels were impacting on all aspects of the service and the system used to determine the numbers of staff and deploy them around the service was not robust.

People were at risk because appropriate arrangements were not in place to handle and administer medicines safely.

The assessment, monitoring and mitigation of risk was not sufficiently robust to ensure people's wellbeing and safety.

Staff were recruited safely and the service was clean with no malodours.

Is the service effective?

Inadequate

The service was not effective.

Nurses and care staff did not received relevant training to ensure they had the skills, knowledge and abilities to deliver care in line with people's needs.

People did not receive appropriate assistance and support with eating and drinking and staff did not always meet people's nutritional/hydration needs.

Competency checks of staff performance were not being completed. Staff supervision was taking place, but did not always cover individual performance or offer staff an opportunity to discuss any work issues they may have. People received appropriate healthcare support from specialists and health care professionals where needed.

Staff were aware of the requirements of the Mental Capacity Act 2005 and the principles of the Act were being followed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated with respect and dignity by some staff.

The care and treatment of people was not always person-centred and did not meet their needs.

We saw staff demonstrate good interactions with people and they were friendly and helpful towards visitors.

Is the service responsive?

Inadequate

The service was not responsive.

Staff were patient and kind when delivering care, but care records were not sufficiently detailed or consistently updated to ensure that person-centred care was delivered.

People had access to a range of activities and enjoyed those on offer.

There was a complaints policy and procedure in place and people were confident in using it.

Is the service well-led?

Inadequate

The service was not well-led.

Although action was taken by the provider and registered manager during our inspection, their oversight of the service had not addressed the shortfalls in the quality of care given and the monitoring of risk to people.

There was a clear leadership structure with identified management roles.

The registered manager had submitted notifications to CQC in a timely way.

People, relatives and staff members were asked to comment on the quality of care and support.

Maple Court

Detailed findings

Background to this inspection

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

This inspection took place on 8 and 13 August 2018 and was unannounced on day one. The inspection team on the first day consisted of two inspectors, a pharmacy inspector and two experts-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The experts-by-experience had knowledge of older people and people living with dementia. The inspection team on the second day consisted of two inspectors.

Prior to our inspection we looked at the information we held about the service, which included notifications sent to us since the last inspection. Notifications are when providers send us information about certain changes, events or incidents that occur within the service. We also contacted North Yorkshire County Council (NYCC) safeguarding and commissioning teams for their views of the service. We did not ask the provider to send us a provider information return (PIR). This is information we require providers to submit at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used the information we held to help plan the inspection.

At this inspection we spoke with one director, the regional manager, registered manager, two deputy managers and nine staff. We spoke with eight people who used the service and ten visitors over the two days of inspection. 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 looked at seven people's care records, including their initial assessments, care plans and risk assessments. The pharmacy inspector looked at medication administration records (MARs) for everyone who used the service. We also looked at a selection of documentation relating to the management and running of the service. This included quality assurance information, audits, recruitment information for three members of staff, staff training records, policies and procedures, complaints and staff rotas.

We gave feedback to the director during the second day of inspection. The regional manager, registered manager and deputies received feedback at the end of each day of inspection. We asked them to send a staffing/dependency tool to CQC and this was received within our given timescale.

Requires Improvement

Is the service safe?

Our findings

We looked at the systems in place for medicines management and found they did not always keep people safe.

Records relating to oral medicines were mostly completed correctly, however we checked a sample of medicines alongside the records for people and found some medication balances did not match up. For example, we looked at one person who was prescribed a medicine for Parkinson's disease and found the medicine stock balances were incorrect in relation to how many administrations were documented on the Medicine Administration Record (MAR). On one unit we also found over a fifteen day period there were four missing signatures on the MAR with no omission codes documented. Therefore, we could not be sure these medicines had been administered correctly.

We looked at the process for the application of creams. There were body maps in place in each person's bedroom to guide staff on where to administer creams and recording of application was completed on an electronic system. We looked at six records and found that in four of these records creams were not being applied as prescribed. For example, for one person a cream was to be applied twice a day, however records showed that the cream had only been applied on six occasions in the last 17 days. We also found in all records that we looked at that care staff did not record which cream they were applying therefore no audit trail could be followed. This meant we could not be sure that creams were being applied as prescribed.

The service used 'when required' protocols to guide staff in the administration of when required medicines. However, we found these protocols were not always in place and others that were did not provide detailed guidance to support staff. For example, one person was prescribed a strong opioid for pain relief however there was no guidance in place to support staff on when this was to be given. A second person was prescribed a medicine for anxiety, whilst there was a protocol in place which detailed this to be given for 'severe anxiety' it did not detail the signs and symptoms of 'severe anxiety' for this individual. Therefore, we could not be sure staff had sufficient information to administer when required medicine appropriately.

We looked at the processes for auditing medicines within the home and found that whilst there were daily and monthly audits they hadn't picked up the issues we found on the day of inspection. We also found the home had not completed an audit in July 2018 due to there being an external audit however we found this audit did not cover the same questions as their own. This resulted in the service being without crucial audit data in July 2018.

We gave feedback to the two managers at the end of day one about our concerns regarding medicines. They said they would speak with staff about their practice and recording on the electronic record system.

These findings evidenced a breach of Regulation 12 Heath and Social Care Act (Regulated Activities) Regulations 2014

People who used the service said they felt safe, but expressed some concerns around the levels of staff on

duty. One person told us, "Some staff don't know how to use the hoist. They have to wait to get two staff together, frequently I am waiting up to three quarters of an hour." We asked staff about this and they told us, "New staff are not able to use the hoists until they have training. Until the training is completed they work with an experienced member of staff." This indicated that moving and handling practices were safe, but some people had to wait a long time for support.

The dependency levels of the people who used the service were used to determine the levels of staff on duty. We looked at a copy of a dependency tool used by the registered manager and checked four weeks of the staff roster; this indicated there were sufficient staff on duty over the 24 hour period to meet people's needs. This included agency nurses and care staff being used on a frequent basis. However, we had concerns about the numbers of staff on duty and how they were deployed in the service.

For example, we noted that one person who was assessed by the service to be at a high risk of falls was not being monitored when in the lounge. On both days of inspection, they fell in this area. After the first fall a member of staff told us, "[Name of person] does this all the time." The person's relative told us, "Staff keep saying to me that they can't watch them all the time and they will fall." The registered manager told us they had applied for additional funding for this individual, to give them some one-to-one input. Two visitors told us their relatives were often found on the floor. One said, "Staff leave [Name of relative] on a mattress on the floor as there is no one to look after them, I found them like that three or four times last week when I came in." Staff told us the two people had behaviours which meant they put themselves on the floor. Staff made them comfortable until they had time to attend to their needs. We observed this during our inspection.

There was a lack of organisation by the nurses and senior staff on duty on both days of our inspection. We observed two people whose care was delivered late or missed. People commented on the fact that they often were late in getting up and dressed by staff. One visitor told us, "When [Name of person] first moved in, it was requested of staff that they were ready for mass at 8:45am as this was very important to them. Staff said they'd done their best to get [Name] ready but had other emergency calls – so [Name] was not fully dressed and hadn't had breakfast." Staff we spoke with said, "Some days I go home and feel completely annoyed and drained. Such as when management say you have enough staff and you know that you haven't given enough time to people as you've been so caught up in one person's care" and "Sometimes it takes longer to get people ready on a morning, sometimes up to 11:00am. [Names of three people] will ring the bell or get frustrated when they've been waiting a long time. One person can't verbally communicate but you can just tell they want to get up. We don't get people up at a certain time, only if they want to be up. It feels like we're meeting people's needs but it can take time."

These findings evidenced a breach of Regulation 18 Heath and Social Care Act (Regulated Activities) Regulations 2014

We gave feedback to the director, regional manager and registered manager during the inspection about the above concerns. They said they were aware of the issues and were looking at further training for the senior staff in effective management practices and organisational skills.

Accidents and incidents were recorded by staff and the registered manager had oversight of these. The information was collated and monitored by the provider, but the evidence about the lack of appropriate staff deployment indicates that trends and patterns were not being picked up on and actioned appropriately.

The service was well maintained and health and safety checks on the fire, electric and water systems were carried out by the maintenance person or external contractors. Fire risk assessments and procedures were

in place. However, when we asked the regional manager about fire evacuation training for staff, they told us they did not think any had been done. We were assured this would be actioned straight away.

A safeguarding policy was in place and staff were aware of how to report concerns. The information we held about the service indicated ten safeguarding issues had been reported between May and June 2018. These had been investigated by the local authority safeguarding team and action had been taken by the provider on recommendations made in the reports.

Communal areas were clean, bright and well furnished. There were no unpleasant odours. People said, "The whole home is lovely and clean" and "Absolutely spotless." We noted that there was no laundry person on duty on a weekend. People and staff said that this caused problems as sometimes there was no clean laundry or clothing on a Monday morning. We spoke with the regional manager about this and they organised weekend cover going forward.

Robust recruitment practices were followed to make sure new staff were suitable to work in a care service. Monthly checks of nursing registrations were carried out to ensure the nurses remained on the Nursing and Midwifery Council (NMC) register and were deemed fit to practice.

Inadequate

Is the service effective?

Our findings

Agency staff profiles were not always in place for the staff working on duty. This meant robust checks on the identity and qualifications of agency staff were not carried out before they worked in the service. The provider's induction for agency staff was not robust and did not cover medicine management, end of life care, verification of death, reporting of safeguarding, accidents and incidents, or the needs of people who lived at the service. A large percentage of the medication errors notified to CQC in the last six months were due to agency worker practice, which indicated this was a high-risk area that needed addressing by the provider.

There were gaps in the staff training plan we looked at. For example, we noted the deputy managers, nurses and senior staff had not attended the training the provider deemed as mandatory such as safeguarding, health and safety, infection prevention and control and dementia awareness. One deputy had not completed safe handling of medicines but was administering medicines. Only one senior member of staff had completed the Mental Capacity Act and deprivation of liberty safeguards training. None of the 35 staff had completed end of life care training and only the registered manager had completed behaviour management training. This meant insufficient numbers of staff had the appropriate skills and competence to meet people's needs appropriately.

During the inspection we observed that staff did not manage people's anxious and distressed behaviours effectively. Not all staff including senior staff had completed dementia care awareness training. We saw people living with dementia walking aimlessly around the service. Their calls for help were distressing for people, visitors and staff and when staff did try to interact with them, this was brief and ineffective. Ten staff including five from the management and senior staff group were booked to attend dementia awareness training. However, staff told us that this should have taken place the week before our inspection, but other training was given priority and it had been cancelled.

Supervision is a process, usually a meeting, by which an organisation provides guidance and support to its staff. Supervisions were taking place on an individual and group basis. However, these did not always address individual performance or offer staff an opportunity to discuss any work issues they may have." The registered manager acknowledged that this aspect of practice needed some development.

These findings evidenced a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Three visitors told us they were concerned about their relatives losing weight. We found the documentation of food and fluid intake was inconsistent and changes to people's nutritional needs were not always carried forward into their care plans. We spoke with the registered manager about our findings and they said they felt confident that weight loss was being monitored appropriately. However, the document they provided as evidence of monitoring showed staff were not risk assessing weight loss over a period of time, but only in relation to the month previously.

Of the 37 people on the sheet 16 of them had lost weight between January and July 2018. One person had lost 20kg over the last six months going from 103kg to 83kg, but their nutritional risk was recorded as amber (moderate). The nutritional records did not include BMI ratings so it was difficult to assess the impact on each individual. We asked the registered manager to check everyone's weight and BMI and to ensure referrals had been made to nutritional experts if anyone was found to be at risk. We received an updated action plan from the registered manager nine days after the inspection. This indicated the actions requested by us had been completed and that errors with weights had subsequently been picked up and acted on appropriately.

People who were independent with eating and drinking and had capacity to say what they wanted for meals, had a positive experience around meal times. However, people with more complex needs or dependent on staff assistance did not always have their needs met. We observed staff at lunch time trying to assist two people at once with eating and drinking, which meant they were rushing and the experience lacked dignity for the people involved. Meals and drinks were left to go cold in the bedrooms and the dining room as staff were too busy to assist people to eat and drink. One person we spoke with required a soft diet and could not cut hard food items. They told us, "Staff do not seem to be aware of what I need and often bring me unsuitable foods." Our observations at lunch time confirmed this statement as the choices offered to the person did not meet their dietary needs. A visitor told us, "[Name of person] is blind, but staff do not tell them that their meals and drinks are on the table, so they go cold." We went to the person's room and saw there were full, cold cups of tea on their table. The registered manager told us that staff were to start two sittings for the lunch time meal following day one of our inspection. This would give staff more time to assist people with their meals and drinks.

These findings evidenced a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. Where people lack mental capacity to make 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 whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the service was following the principles of the MCA and where needed applications for DoLS had been made by the registered manager. Staff understood about MCA and DoLS, but they were unable to tell us which of the people they were supporting had a DoLS in place, which meant there was a possible risk of people's rights being impinged upon. The registered manager told us they would ensure staff were given the appropriate information and going forward it would more accessible for staff to read.

The majority of relatives who spoke with us had power of attorney in place for health and wellbeing and had been consulted by staff on admission about the care and support needs of people who used the service. However, two visitors said they had not been included in this process even though they had supported their loved ones over a number of years with their care needs. One person said they felt quite isolated by the staffs' lack of compassion and understanding of their need to be part of their relative's care. We gave feedback to the registered manager about this at the end of the inspection. They said they would speak with the families concerned.

Evidence in the care files showed that people had good access to healthcare professionals such as the dentist, optician, and some people had regular input from the district nurses. People told us, "An appointment or visit would be arranged quickly if you needed it" and "On the odd occasion I have wanted to see the nurse they have come quickly. I had the doctor recently as I was concerned I had an infection." One visitor told us, "My relative has needed a doctor a couple of times for odd reasons, each time the staff arranged it straight away." Hospital passports were in place, but some of the information within them was out of date and did not reflect their current needs. This was fed back to the registered manager who said they would ensure the passports were updated.

The environment was clean, tidy and well maintained. Appropriate equipment was in place to assist staff when moving and handling or supporting people with their care. This included specialist beds, hoists and sensor mats. All equipment was in good working order and ensured the care being provided was safe and effective.

Thought had been put into the design of the environment in relation to people living with dementia. There was sufficient signage on communal facilities such as toilet and bathroom doors to help people access and use facilities as needed. The bedroom doors were numbered and had names and pictures of something memorable to that person to aid their orientation. Those bedrooms we saw were personalised and comfortable.

Requires Improvement

Is the service caring?

Our findings

We received several comments from staff, people and relatives about the poor-quality care and a lack of compassion delivered by some of the agency staff working in the service. Staff told us, "Some of the agency care staff do not communicate with people very well, and some lack patience." We observed one agency staff left the person they were supporting with one-to-one care alone in the lounge whilst they went back to collect their slippers. The person who used the service was agitated and distressed and presented a potential risk to the safety of others. An agency worker was supporting another person who was very frail and restless. When the person stood up the agency worker did not give any encouragement with mobility as they were watching the television in the lounge. The registered manager told us they would speak with the staff about their practice. Staff confirmed that when they reported poor practice to the registered manager the agency staff were not used again in the service.

Although people who used the service said they felt the staff protected their privacy and dignity we found staff practices were not consistent in promoting this. People were left waiting to get up until late in the morning. One person we spoke with asked if they could be washed and dressed and staff told them, "Yes, after breakfast." This was at 10:40am and we noted they were only attended to just before noon. Staff told us they often ran out of people's clean clothes after the weekend when there was no laundry staff on duty. One visitor told us, "At times I visit and find [Name of person] is not wearing their own clothes. One day they were wearing a navy-blue t-shirt, but they only wear cotton shirts."

We saw two people lying on their bedroom floors where staff had put a pillow under their head to make them comfortable until they could attend to them. Visitors confirmed to us that this was a usual occurrence. One visitor told us, "The doors are left open of those who can't manage, you see people laid on the floor half dressed, I've seen it a few times." They confirmed to us that the person would be on a mat on the floor. The family of one person said their relative had been reassessed recently for more appropriate seating as it was thought this was one reason they put themselves on the floor. However, to date nothing had been done about purchasing the necessary equipment and they were waiting for a meeting with the funding authority to discuss their care.

These findings evidence a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We did observe some very kind and caring interactions between staff and people who used the service. We saw a member of staff encourage a person to have a drink; when they only took tiny sips, the staff sat with them and supported the cup to aid them drinking. We observed another person being transferred from a wheelchair to a chair in the lounge. Two care staff carried out this task using appropriate equipment. It was evident they were familiar with this and ensured the person placed their hands in the right position before starting the transfer. They engaged with the person during the process and the procedure was handled competently and in a caring manner. We received some positive comments about the staff and the support they gave to individuals. People told us, "Staff encourage people to take regular exercise and use appropriate walking aids when they do", "Staff are doing the best they can. They are always polite and

helpful" and "Staff are kind and caring, they cannot do enough for you." People and relatives said staff listened to them and offered assistance if asked. One visitor told us, "My relative does not say much, but staff do engage with them."

The registered provider had a policy and procedure for promoting equality and diversity within the service, but this was not always achieved in practice. Equality and diversity information such as gender, race, religion, nationality and sexual orientation were recorded in the care files. We saw that people using the service had different faiths. The majority of visitors and people living in the service confirmed that they were able to take part in services in the home and individual arrangements could be made for visits from different clergy on request. However, we found that for one person their spiritual needs regarding attendance at mass, which were very important to them, had not been fulfilled.

Care files were kept secure and behind locked doors when not being used. Staff who spoke with us were aware of the need to keep information confidential at all times.

For people who wished to have additional support whilst making decisions about their care, information on how to access an advocacy service was available from the registered manager. An advocate is an independent person who supports someone so that their views are heard and their rights are upheld.

Inadequate

Is the service responsive?

Our findings

The service was not responsive around some aspects of care. We found that people's care plans and other care documents did not always clearly describe their needs or record the care being given.

We looked at seven care files, associated risk assessments and additional care documents such as food and fluid charts and repositioning records. We found people with specific health care needs such as diabetes or mental health issues did not always have detailed care plans to guide the staff in giving appropriate care. For example, we looked at one care plan for a person with diabetes. Whilst their care plan detailed their treatment for their diabetes it did not document any signs or symptoms of low blood sugar levels to guide staff on the appropriate course of action should this occur. Therefore, we could not be sure staff could manage this condition appropriately.

One member of senior staff told us, "I have a lot of learning needs and just want to hurry up and have the training so I feel comfortable. I feel confident with basic physical observations, but I am not confident with pressure care and will do some on-line training for myself."

Another care file we looked at did not have up to date information on the person's care needs and their risk assessments were not robust or reviewed effectively. For example, the person's health condition had deteriorated and they were now nursed in bed and needed full staff support with aspects of daily living such as personal care and eating and drinking. They also required repositioning every four hours and were on food and fluid charts to document what they were eating and drinking as they were at risk of poor nutrition. We found their moving and handling risk assessment did not identify their need for bed rails (which were in place). The person's falls risk assessment still referred to them as semi-mobile when they now remained in bed full time. Their nutritional care plan had not been updated to show they needed assistance with eating and drinking. A risk assessment had been completed for mental health and it identified they had depressive symptoms but there was no corresponding care plan for staff to guide them in how best to support the person's needs. This meant staff did not have up to date information on how to meet the person's needs, which put this individual at risk of harm.

One member of staff who spoke with us said, "Everybody's getting their basic care, but drinks and repositioning can get missed especially through the night." When we asked them to clarify what they meant they said, "We don't know what staff have done or not done as staff don't record it. Last night one person was poorly through the night but nothing was logged on the system. So I asked the deputy manager who said it sometimes comes up on the computer records but not on the tablet."

We looked at food and fluid charts for two people who used the service. We found there was a lack of documentation of people's total fluid intake and output for each day. Records of food consumed were poorly completed. For example, one person's records showed on 7 and 8 August 2018 there were no food entries for breakfast. No records of any suppers and only drinks were recorded outside the actual meal times, so there were no records of snacks. Daily fluid intake records from 6 to 8 August 2018 showed the person consumed between 300 and 720 millilitres on a daily basis. The daily records did not document the

target fluid intake for this person and there was no evidence that staff had taken any action in response to their poor intake of fluids. We spoke with one of the deputy managers who agreed these needed to be more robustly completed. The lack of monitoring and risk management meant people could be at risk of dehydration or malnutrition.

One person's care file documented they were at risk of pressure damage and required pressure relief support from staff every four hours. Their repositioning records for 11 and 12 August showed no interventions between 08:43 and 19:04. On 8 August 2018 there was an entry to say the person received support at 06:00 but then no further entries until 19:31. These records indicated that staff did not give them the appropriate support they required and they were put at risk of developing pressure sores.

Care plans recorded when people had a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) in place and staff had 'Just in case' medicines in stock for certain individuals. These medicines are prescribed by GP's and are used to ensure people on end of life care are kept comfortable and pain free. We saw that basic information about end of life care such as funeral arrangements and who to contact about these details were documented in people's files. However, for one person whose care we looked at we found there was a lack of information about friends and family that the person may wish to have near them at the end of their life. There was also no guidance for staff on who to contact when the person was in distress, things that may calm the individual and details of their faith. Their hospital passport contained out of date information from when the person was more independent and needed updating. Following our inspection, we received a complaint about poor end of life care and support following the death of this individual. This is currently being looked at by the provider.

These findings evidenced a breach of Regulation 12 Heath and Social Care Act (Regulated Activities) Regulations 2014

There was a complaints policy and procedure on display that was available in both large and small print. People and relatives said they were confident of making a complaint when they needed to, but some people felt their issues were not always managed effectively. A visitor said they had raised concerns with the management team, but they were made to feel as though they were in the wrong for doing so. This had left the visitor feeling left out and alone without support. These concerns were discussed with the provider and registered manager on day two of inspection. We were given assurances that complaints were taken seriously and investigated thoroughly. Records that we looked at showed there had been eight complaints since the service opened, all of which had been responded to and found to be substantiated.

The provider was aware of the Accessible Information Standard (AIS), which sets out a specific approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of people with disabilities, impairment or sensory losses. They acknowledged that they needed to develop their approach to this around assessing and identifying and then managing people's individual communication needs.

People and visitors were extremely complimentary about the activity person who worked within the service. Comments included, "[Name of activity person] is marvellous" and "At first there wasn't a great deal to do, but this is a new place and it takes time. I don't remember seeing them [Activity Organiser] in the first week or two but they are here every day now. We do armchair aerobics every week, we've had a pyjama party and we play games and there's going to be a summer fair shortly, we've had outside entertainers. There was a sherry party yesterday. We've started going to a coffee morning at the church, three of us went, they were playing bingo but I just sat and talked to the people from the church."

We saw and heard music playing on the first floor. People appeared to be enjoying the music. Quite a few were swaying and waving their hands in time to the music, (some were smiling). We were told about half the people took part in activities, but some preferred to have one-to-one time with the activity person. This was confirmed by one person who said, "I don't do activities through choice, but [Activity person] comes by, sits and talks with me." Another person said, "I am spoilt, I have half a day with [Activity person]. We go across the road to the day club at the church."

Inadequate

Is the service well-led?

Our findings

The provider and registered manager had carried out monthly audits from November 2017 to July 2018. These had identified shortfalls in the service provision and risks to people who used the service with regard to poor documentation and lack of care around health and well-being. However, insufficient action had been taken by the provider to mitigate these known risks.

The provider told us they recognised the registered manager had been struggling to manage all the issues identified in the service and had assigned a regional manager to give them support. A recovery plan had been created by the provider in July 2018, but this was too recent to have had much of an impact so people who used the service remained at risk of receiving non-compliant care and treatment.

A dependency tool was used to determine the number of staff and the range of skills required to meet the needs of people using the service and to keep them safe. However, we found this did not mean people received appropriate care. We found people had to wait for attention from staff and some individuals did not receive appropriate support as staff struggled to meet everyone's care needs.

Staff training was not up to date and staff lacked the knowledge and skills to recognise risks to people's health and safety. We found that agency workers did not receive a robust induction when they commenced shifts at the service. This meant we could not be certain that some staff had the appropriate training and skills to meet people's needs. This had not been identified or acted upon by the registered manager or provider.

The quality of record keeping was inadequate with a lack of up to date risk assessments and care plans to guide staff in delivering effective support and care to people who used the service. Food/fluid charts and repositioning records were not well recorded and information about people's care was not in accessible formats. This meant that staff did not have access to complete and contemporaneous records in respect of each person using the service, which potentially put people at risk of harm.

During the inspection we found that systems and processes were not established and operated effectively to ensure the service was assessed or monitored for quality and safety in relation to the fundamental standards. This led to breaches of regulation in relation to nutrition, privacy and dignity, staffing, safe care and treatment and good governance. This meant people who used the service were at risk of harm.

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

There was a registered manager in post who was supported by a regional manager and two deputy managers. We received mixed feedback from people and visitors about the management of the service, but overall people did feel the service was slowly improving. One person said, "There have been ups and downs since it opened, but I think things are better now than in the beginning."

Two visitors told us, "The manager is capable but seems over-stretched, seems to have a lot to do but they are responsive, they don't fob you off." and "I don't know them really well, obviously well trained. They don't really communicate with me very much, a little aloof. They are okay when you go and speak to them."

People using the service said, "There are irritations to do with living here and those depend on the staff knowledge and experience" and "I don't think there is one best thing, it's well furnished but then it's new, very pleasant and light, I can't fault it, the people are nice, the food is good, I'm settled."

Progress was being made in gaining insight and viewpoints from stakeholders. The registered manager had organised a range of meetings for staff, people and visitors since the service opened. One visitor told us, "I've seen a list of meetings, I think the first relative's meeting is in November, looks like they will be held twice a year. I think residents' meetings are every three months." However, people, visitors and staff spoke to us about their frustrations with communication in the service, with messages not always being passed on or action not being taken where needed. The registered manager told us they would be developing the handover sheets for staff so information was relayed effectively from shift to shift. They held meetings each morning with heads of units to discuss any concerns in the service.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The registered manager had informed CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect at all times, including staff not treating them in a caring and compassionate way. People with distressed behaviours and those dependent on staff to get them up in a morning were left in undignified situations. Regulation 10 (1) (2) (a-c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for people who used the service. Risks to people's health and safety and the mitigation of those risks were not sufficient to keep people safe from harm, including those around medicines management and competent staff Regulation 12 (1) (2) (a-c) (f-g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The nutritional and hydration needs of people who used the service were not met through a lack of robust assessment, monitoring and support. Regulation 14 (1) (2) (4) (a) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Governance and record keeping processes were ineffective in monitoring and improving quality and safety of the service, assessing and mitigating risks to people who used the service and maintaining an accurate, complete and contemporaneous record in respect of each person using the service. Regulation 17 (1) (2) (a-c) (e-f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing In-sufficient numbers of suitably qualified, competent, skilled and experienced staff who could meet the needs of people who used the service and keep them safe at all times were employed. Staff did not receive appropriate support, induction and training to enable them to carry out the duties they were employed to perform. Regulation 18 (1) (2) (a)