Bupa Care Homes (GL) Limited

Burley Hall Care Home

Inspection report

Cornmill Lane
Burley-in-Wharfedale
West Yorkshire
LS29 7DP

Tel: 01943863363

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 5 January 2017 and was unannounced. At the last inspection on 7 April 2016 we rated the service as 'Requires Improvement'. Although we did not identify any breaches of regulation, we had some concerns regarding leadership within the home.

Burley Hall Nursing Home is located in Burley-in-Wharfedale near Ilkley and provides nursing and personal care for up to 51 older people, some of who are living with dementia. There were 37 people using the service when we visited. Accommodation is provided in two houses; Greenholme house accommodates up to 17 people living with dementia and Wharfedale house accommodates up to 31 people with nursing needs. There are 45 single rooms and three shared rooms, which are currently used for single occupancy. There are communal areas on each house and access to garden areas.

Overall people and relatives provided positive experience about the home and said good quality care was provided that met people's individual needs. However some people and relatives raised concerns about lack of staff and poor staff morale.

People said they felt safe living in the home. Risk assessments were in place which showed risks to people's health and safety had been assessed and clear plans of care put in place. In most cases we saw safeguarding incidents were appropriately managed, although we identified one incident which had not been reported to management for action.

Overall medicines were safely managed, although due to inconsistent record keeping there was a lack of accountability for some medicines.

We concluded there were not always sufficient staff deployed to ensure consistently safe care and treatment. Staff all told us there were not enough staff, particularly in the Greenholme house and we observed several instances where staff were not present to safely oversee communal areas.

Safe recruitment procedures were in place to help ensure staff were of suitable character to work with vulnerable people.

Staff received appropriate induction and refresher training in key subjects to help ensure they had the correct skills and knowledge to care for people. People told us staff were competent and staff demonstrated to us they knew people well and their individual needs.

People had access to a choice of suitably nutritious food. Arrangements were in place to ensure people's nutritional needs were met and action was taken where people were deemed to be at risk.

The service was acting within the legal framework of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

People's healthcare needs were met and appropriate plans of care put in place. The service liaised with external health professionals where required.

People and relatives said staff were kind and caring and treated them in a respectful manner. This was confirmed by our observations of care and support. Regular staff knew people well and positive relationships had developed.

People's care needs were assessed and detailed and appropriate plans of care put in place. We saw in most cases care plans were followed. However we found a lack of evidence pressure area care interventions were carried out in line with plans of care.

Two activities co-ordinators were employed who provided people with a varied range of activities.

A system was in place to log, investigate and respond to any complaints. Most people and relatives we spoke with were satisfied with the care provided.

Staff told us morale was poor, there was a lack of team working and/or they did not feel well supported by management. We were concerned of the impact widespread negative staff sentiment could have on the overall quality of the service provided.

Systems to assess, monitor and improve the service were in place. In some instances we saw these were successful in highlighting issues and driving improvement, but further work was needed to review some areas such as medication and care and support charts.

People were encouraged to provide feedback on the service through several mechanisms and this was used to help make improvements to the service.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations. You can see what action we asked the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Overall medicines were safely managed, although clear records were not kept so we could not account for all medicines.

Staff told us staffing levels were not sufficient particularly in the Greenholme House. We concluded there were not always enough staff deployed in the right places to ensure appropriate care. Robust recruitment procedures were in place.

People told us they felt safe using the service. Risks to people's health and safety were assessed and clear and up-to-date plans of care put in place.

Is the service effective?

Good

The service was effective.

The service was acting within the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff were provided with a range of training to undertake their role effectively. Staff supervisions needed to be updated.

People had access to a choice of food and drink. Nutritional risks were appropriately managed by the service.

Is the service caring?

Good

The service was caring.

People and relatives provided positive feedback about staff and said they were treated with dignity and respect.

People said caring relationships had developed with regular staff. We saw staff knew people well and were aware of people's individual care and support needs.

People felt listened to and involved in their care and support.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People told us they received appropriate care and people's needs were assessed. However documentation indicated people were not always receiving timely pressure area care interventions.

A range of activities was provided to people led by two activities co-ordinators.

A system to log, investigate and respond to complaints was in place.

Is the service well-led?

Inadequate

The service was not well led.

Feedback from staff about management, team working and how concerns were managed was very poor. Staff reported poor morale in the service.

Systems to assess and monitor the service but these were not always sufficiently robust. An accurate record of each service users' care and support was not always kept.

People's feedback was sought and used to make changes to the service.

Burley Hall Care Home

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 5 January 2017 and was unannounced. The inspection was carried out by two inspectors and an expert by experience with expertise in older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioning and safeguarding teams.

We spoke with ten people who were living in the home, seven relatives, 13 care workers, 3 nurses, an activity co-ordinator, the cook, the interim manager and the regional director.

We looked at five people's care records as well as records relating to the management of the service. We looked round the building and saw people's bedrooms and communal areas.

Requires Improvement

Is the service safe?

Our findings

Medicines were administered by registered nurses or trained senior care staff. We observed the medicines round and saw medicines were administered in a calm and unhurried manner, with the staff member remaining with people until their tablets had been taken. Staff took the time to explain what each tablet was for and we saw they knocked on people's doors, asked if the person was ready for their medicines before administering and signed the medicines administration record (MAR) after the administration had been completed. However in the Wharfedale house we noted the nurse administering medicines broke off from this task to assist one person to the toilet and also took a phone call when other staff were busy in other people's rooms, despite wearing a tabard indicating they should not be interrupted during the medicines round. It is particularly important that the person administering medicines is not disturbed whilst performing this duty to reduce the risk of medicines errors. We discussed our concerns with the interim manager and regional director who agreed this should not have occurred.

Overall we concluded most people received their medicines as prescribed. People's MARs and records for the receipt, administration and disposal of medicines were well completed. However we found some discrepancies between the number of tablets in stock and what should have been present according to records kept. For example, in the Wharfedale house we checked five medicines and found discrepancies in all cases. In the Greenholme house we found further discrepancies. In two other cases it was impossible to reconcile stock balances due to a lack of recording. This meant there was a lack of accountability for medicines and demonstrated a lack of accurate record keeping.

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

We saw liquids, creams and eye drops in use had opening dates on them. All medicines, including controlled drugs were stored securely and appropriately. We checked stock levels of controlled drugs and found these to be correct and administration recorded correctly. Medicines refrigerator and storage temperatures were recorded and checked daily to ensure medicines were stored at the correct temperature.

We looked at the records of people who received their medicines covertly (in a disguised format). In each case the records showed the decision to administer medicines in this way had been taken in the person's best interests with the involvement of staff, relatives and health care professionals.

Medicines were stored securely and the temperatures of the storage areas and medicines fridges were monitored to make sure medicines were stored at the recommended temperature. Some medicines have particular instructions about when they should be taken in relation to food. We found there were suitable arrangements in place to make sure these instructions were followed. When people were prescribed medicines to take 'as required' there was guidance in place to help make sure they were used consistently.

On the day of the inspection we observed that there were 11 nurses and care assistants on duty, supported by a hostess and two activity coordinators. The staff on duty reduced by one care assistant in the afternoon.

At night the home had a minimum of five staff on duty, very often we observed from the staffing rota this would be a minimum of six nurses and care assistants for the 37 residents. The Regional Director shared with us the outcome of the assessments analysed through the dependency tool. This is one piece of information used by the home to assess the dependency of every resident, reviewed at least each month, that helps determine the staffing level and mix required to meet the changing needs of residents. This tool indicated there were sufficient staff within the home.

People and relatives provided mixed feedback about staffing levels. One person told us, "I use the buzzer occasionally, I get a good response," and a relative told us, "I believe there are a lot of staff." Another relative told us, "It goes in phases. It has concerned me in the past but not in recent times. The home isn't full at the moment." However a number of relatives we spoke with also said there were not enough staff. One relative we spoke with said that although the care was excellent, more staff were needed. They said, "Mum gets upset as has to wait a long time when she rings the bell. Staff come in and say 'back in a minute' but she waits and waits." A second relative told us, "They rush off after moving him and they don't wait to see if he is happy with the new position. It takes him a minute or two to know if he will be comfortable." A third relative told us, "There should be more consistency in the lounge where people sit. Sometimes it's as if they have been left there."

Nearly all staff raised concerns to us around staffing levels at the service, particularly during the night period and at weekends. Although these comments referred to a lack of staff throughout the building, staff raised particular concerns about staffing levels at night and in the Greenholme house. Comments from staff included, "The dementia unit [Greenholme] is very hard with just a carer and a senior [on night duty]. I don't think it's safe. I feel vulnerable", "Don't think it's safe [referring to the Greenholme house]. One person is very unpredictable. When the senior carer is giving out medicines it's just you looking after everyone", "We don't think are properly staffed, difficulty is if some residents are up and the senior is doing the medicines we cannot physically keep an eye on people", "People lack interaction, they are left wet longer," and, "People have to wait for the toilet." The regional director told us they were aware of the concerns raised by staff but their staffing tool had demonstrated there were enough staff deployed to keep people safe.

On the day of our inspection there were adequate staff deployed to respond to people's needs in a timely manner in the Wharfedale house. However some staff commented on how staff numbers had impacted upon interaction with people who used the service. One staff member said they felt they were task focussed and commented, "I feel personal care gets done but we don't get chance to sit and chat with people." Another staff member commented that people's charts such as food, fluid and positional charts were not always being completed due to time constraints. During our inspection we found these charts were not always correctly completed.

In the Greenholme house during observations we found staff were not always deployed at the right times to keep people safe corroborating staff sentiment about this house. In the morning we observed a lack of staff around the house between 7.20am and 8.20am. People were taken to the lounge during this period and left in a room with no interaction, stimulation or access to drinks. We saw one person approached another and started touching their hair which caused the person to become distressed. There were no staff around to intervene. Later in the morning we saw one person went into another person's room and tried to assist them to stand up which could have resulted in an accident. On reviewing their daily records we found they had been found in people's rooms at night a number of times. Another person's care plan showed they should be supervised whilst sitting in a 'comfy chair' in the lounge. We observed they were left in their wheelchair all morning, rather than transferred to a comfy armchair. Staff were not always present to offer appropriate supervision of the lounge had they been transferred to a comfy armchair.

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

Safe recruitment processes were in place and found to be thorough which ensured staff were suitable to work in the service. These included ensuring staff completed an application form, attended an interview, provided references and undertook a Disclosure and Baring Service (DBS) check. Staff we spoke with confirmed these checks had taken place before they were able to start work.

People told us they felt safe in the home. One person told us, "I like living here, they don't beat me or anything." Another person told us, "I have no concerns; I'm quite happy." Safeguarding procedures were in place and we saw evidence they had been followed. All the staff we spoke with confirmed they had received safeguarding training, understood what constituted abuse and what to do if they were concerned about someone in their care. We saw safeguarding and whistleblowing information was displayed prominently within the service. In most cases we saw evidence of safeguarding incidents being reported and acted on. However, we saw from records one person had been found in another person's bed on 1 January 2017. No safeguarding referral had been made to the local authority or notification to the Care Quality Commission. When we spoke with the interim manager about this they were unaware of the occurrence and stated this information had not been passed on. They concluded this was because the agency nurse on duty had not followed the correct procedure. The management then took action to make a safeguarding referral on the day of the inspection. We were informed it was closed on the same day by the adult safeguarding team as they were satisfied with the actions taken by the home.

Risk assessments were in people's care records appropriate to their individual needs such as bed rails, mobility and nutrition. These demonstrated risks to people's health had been assessed and clear advice recorded for staff to follow. People and relatives told us risk assessments were updated and/or put in place following incidents. One relative told us, "They communicated with us about the falls to reduce risks."

The premises was safely managed and suitable for its purpose. People and relatives provided positive feedback about the environment. One person told us "Home is kept immaculate, very clean and laundry service is very good." We conducted a tour of the premises and found it to be clean and well maintained, with people's personal items displayed in their rooms such as ornaments and photographs. There were sufficient quantities of communal space for people to spend time including a lounge and dining room in each house as well as quieter spaces. A large garden area was available which people said was well used in the summer time. A maintenance worker was employed to ensure the safe maintenance of the building. Key safety checks were undertaken which included water, gas, electric and water systems and equipment was regularly serviced and checked such as hoists and other lifting equipment. Radiators were covered to prevent the risk of people touching a hot surface and window openings restricted to reduce the risk of falls.

Good

Is the service effective?

Our findings

People and relatives we spoke with praised the care provided, said it was effective and met people's individual needs. One person told us, "Staff are fine, I feel well looked after." Another person told us, "I think its first class."

Staff told us the training provided by the service was good and gave them the required skills and knowledge to undertake their duties. New staff were required to complete a five day induction which included training in a range of subjects as well a week's shadowing to ensure they were familiar with people living in the home. Staff received regular updates in topics such as moving and handling, nutrition, fire safety and safeguarding. We saw a training report which showed 93% of staff were up to date with mandatory training.

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 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.

Management staff understood their duties under the MCA and DoLS. We found appropriate DoLS applications had been for people whom the provider believed lacked capacity and had their liberty deprived by care and support arrangements. In Greenholme, the house manager told us standard authorisations had been submitted to the supervisory body for all people living in the house and a number of DoLS were in place. We saw a system was in place to flag up when authorisations expired to enable reapplication. A recent audit had been undertaken of current DoLS authorisations to ensure conditions were being complied with and the house manager was working their way through these actions to ensure compliance with conditions was robustly documented. We were told us no one living in the Wharfedale house had a DoLS authorisation in place although they had recently applied for five authorisations which were still with the supervisory body awaiting a decision.

We saw where issues around lasting powers of attorney required consideration in care planning this was clearly recorded in the care file. Care plans showed people were given the opportunity to consent to their care and support plans. People and relatives we spoke with told us consent was sought before care and support interventions undertaken.

Discussions with staff demonstrated to us the service was acting within the legal framework of the MCA. Where people lacked capacity, we saw evidence of a best interest process, for example in deciding whether covert administration of medicines and other care interventions were in people's best interests.

Overall people provided positive feedback about the food. One person told us, "It's quite good, never marvellous. I'm not very fussy." Another person said, "They give me a choice, but I'm easily satisfied." A third person said, "The food is fantastic. He gets 5 stars for some of his dishes." However one relative told us, "I've enquired about the food. It's very basic, especially in the evenings; sausage rolls and beans twice a week. They could be more adventurous; the menu is a bit repetitive." People said food was provided at the right consistency to meet their needs, for example pureed, they received their nutritional supplements as prescribed and were regularly weighed.

We spoke with the chef who explained the menu provided a daily balanced diet which had been carefully thought out to provide nutritious and healthy food for people who used the service. The menu was changed seasonally, was on a four week rotation and utilised fresh produce wherever possible. They told us they had daily meetings with staff about any dietary requirements and were given a weekly 'dietary alert' sheet which showed which people required specific diets. They explained how they fortified food with full fat milk, cream, butter and milk powders and were able to tell us where they were working with staff to help support a person with a low fat diet through the provision of lower fat food such as fruit instead of puddings

The daily and weekly menu was clearly displayed in the corridor outside the dining rooms as well as information about other options and 'out of hours' food available. We observed people were offered a choice at breakfast with cereals, porridge, toast and cooked breakfasts on offer. People were offered a variety of fruit juices and a choice of tea or coffee. We saw tables were well presented with cloths, napkins, condiments and table decorations.

We heard kitchen staff spoke with people during the morning and afternoon about what they would like to eat for their lunch and evening meal and they were clearly offering choices from the menu and other options if the person did not want to eat from this. For example, we saw the chef prepared an omelette for someone's tea and a boiled egg and toast for another since this is what they wanted to eat. Where sandwiches were offered, people were asked for their choice of filling and if they required brown or white bread. Mealtimes were unhurried with people allowed to eat at their own pace and people encouraged to consume a good diet. Drinks and snacks were offered mid-morning and during the afternoon, with a variety of biscuits, cakes and fresh fruit.

We saw where people had been referred to the SALT team information about the recommendations had been given to the chef, such as the need for a soft diet, or a specific recommendation for the use of mango juice for two people. Where recommendations had been made we saw these had been acted upon. People's weight was monitored, risk assessments undertaken and appropriate plans of care put in place to help people gain or maintain weight.

People's healthcare needs were assessed and appropriate plans of care put in place. Staff we spoke with had a good understanding of the people they were caring for and their healthcare needs. Health care professionals we spoke with provided good feedback about the effectiveness of the service. We saw appropriate liaison and referral to external professionals where specialist input was required. People and relatives reported access to healthcare professionals, for example if people's weight dropped.

Good

Is the service caring?

Our findings

People and relatives we spoke with praised staff, said they were kind, friendly and treated them with dignity and respect. A person told us, "Staff are kind." Another person told us, "Yes, they look after me well, the staff are friendly. We get on well together." A relative told us, "Nurses and carers are excellent, very helpful, caring and patient." Another relative told us, "Staff are lovely, wouldn't say anything bad about them, they are very caring." A third relative told us, "They take an interest and they make an effort."

During observations of care and support we saw staff treated people in a dignified and respectful way. We observed care and support and found staff were warm and kind to people, displaying compassion and friendliness. Staff assisted people patiently, using appropriate techniques to divert people who had become distressed. Staff spoke with people in a calm and patient manner, even when busy. However, we noted staff appeared 'task focussed' especially at busy times and they told us they didn't have time to sit and chat with people.

We saw people's privacy was respected. For example, we saw staff knocking on people's door and saying who they were before entering. Staff took care to ensure people's clothing was adjusted to maintain their dignity and closed doors during care interventions.

People looked clean and well-dressed indicating their personal care needs were met by the service. Most people and relatives we spoke with told us staff ensured people were always clean and appropriately presented. One person told us, "They fill the bath and it's lovely and foaming water. They wash me and dry me and when you can't do it, it means everything." However two people did mention they wished staff had time to ensure they had a bath or shower more often.

Care staff we spoke with had a good understanding of the people they were caring for, although due to agency usage within the home, we concluded this would not always be the case. One relative told us although regular staff knew their relative well sometimes agency staff did not and the atmosphere when a number of agency staff were on duty was not the same. Information on people's likes, dislikes and life history was present within people's care and support plans. This showed the service had taken the time to learn about people to aid in the provision of personalised care and support.

People were listened to and their choices respected by staff. One relative told us they felt listened to as they had asked for breakfast to be served at a particular time and the service had responded and ensured this arrangement was followed. We saw people were asked what they wanted to eat and drink, what they wanted to do and where they wanted to sit. For example on the morning of the inspection, Holy Communion was held and people were asked whether they wanted to attend and their choices regarding this respected. People were asked for their consent by staff during care and support interventions and during the medication round. Care records showed people had been consulted about care and support arrangements. Other mechanisms were also in place to listen to people including periodic resident and relative meetings and annual surveys.

People and relatives reported no restrictions on visiting the home. One relative told us, "I can visit whenever I want to."

Requires Improvement

Is the service responsive?

Our findings

People and relatives said that overall care needs were met by the service. One relative told us, "They are certainly looking after him," and another relative said the care was "Very good." One person told us they got all the required help and support they needed. They told us, "Yes, they do everything in their power to help when I need it."

We saw people's care and support needs were assessed prior to moving to the service and plans of care put in place. Care records were comprehensive and person centred. These included life histories and information relevant to the person including likes, dislikes and care needs. A range of care and support plans were in place which covered areas such as moving and handling, mental health, eating and drinking. We saw care records were largely up to date and reviewed regularly and there was evidence people and/or their relatives were consulted about how they wanted their care to be delivered. One relative told us, "We have reviews about yearly but staff are approachable about various problems." Another person said, "We have regular reviews and you can always talk to staff. Staff always call me if there is any change."

In most cases we saw people were cared for in line with their plans of care. However we found care and/or documentation with regards to pressure care intervention needed improvement. Some people who had been assessed 'at risk' with skin integrity had 'turning charts' in place for staff to complete. We reviewed some of these charts and saw these were not always completed within the specified time. For example, one person on a four hourly repositioning chart was shown to be repositioned at 16.00 and 22.00 on one occasion, at 15.50 and 20.50 on another day and 1532 and 2300 on a third day. Another person placed on four hourly turns was repositioned one day at 21.40 and the next day at 02.10, 09.00, 14.50 and 21.05. This lead us to conclude either people were not always being turned according to their care plans, or paperwork was not being correctly completed. These charts were not subject to proper review and audit to check they were being completed correctly and highlight any discrepancies with staff involved.

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

Most people told us they were happy with the range of activities on offer and could do what they pleased. A programme of activities was on offer which was posted on the notice board opposite the lounge as well as information on weekly activities delivered to people's rooms. The service employed two activities organisers between the two houses. Activities included reminiscence afternoons with specific themes, games, exercise, baking and quizzes. We saw Holy Communion was offered regularly by visiting clergy and a hairdresser visited weekly. The interim manager told us they were going to be introducing themed food events and we saw the first had been planned to coincide with the Chinese New Year later in January. Entertainers visited the home and outings to local places of interest were also organised. Links were in place with the local community and church. Whilst activities took place, the interactions we observed particularly in the morning were very task based with staff not having time to interact with people in a meaningful way.

The complaints procedure was brought to the attention of people who used the service through displays

and in the information booklet about the home. A system was in place to log, investigate and respond to complaints. We saw complaints were responded to in a timely way. A compliment and suggestion book had also been recently introduced to help capture more informal comments about the home. We saw the home's management had met with people to discuss any concerns and kept them up-to-date about changing management arrangements within the home so they knew who to approach with any queries or concerns.

Inadequate

Is the service well-led?

Our findings

A registered manager was not in place with the last manager de-registering in June 2016. An interim manager was in place at the time of the inspection overseeing the home. The Regional Director told us of planned management changes to the home and confirmed that all residents, relatives and staff had been kept up-to-date regarding management changes within the home. For example the appointment of a permanent home manager had been discussed at the last resident and relative meeting in November 2016. The appointment of the new home manager had been confirmed recently in writing to everyone connected with the home and their start date of 9 January 2017 confirmed .

At the last inspection in April 2016 we had concerns about leadership of the service and feedback we received suggested the registered manager did not promote an open, inclusive and empowering culture which encouraged concerns or suggestions to be raised with them. At this inspection we found there was still a lack of open, inclusive and empowering culture and widespread concerns were reported to us about leadership, morale and/or team working. Staff also had significant concerns about staffing levels which it was clear had not been effectively addressed with them.

The regional director told us they had recently attended a resident and relative meeting, where everyone present had been positive about the contribution and impact that had been made by the interim Home Manager. In addition, group and individual staff meetings had been held and concerns around staffing levels, staff deployment and care needs had been discussed. The regional director told us that these meetings had been positively received.

However the majority of staff we spoke with expressed concerns about the poor morale at the service and some told us this was due to various issues such as friction between staff, staffing levels and management changes. Comments included, "Everyone is fed up", "Morale is at an all-time low", "Morale very low", "I love the residents but there's low morale due to staffing and lack of managers", "I'm not happy.", "Staff morale is not existent", "I think morale is at an all-time low. Don't think we're listened to", "I think morale since August/September and progress made previously is gradually going back," and, "You come in and you don't want to be at work." However one staff member told us they thought morale had recently improved.

Staff expressed differing views on the cause of the problems but said there were poor relationships between staff and management. Comments included, "Don't feel listened to, it is a very one sided conversation[with management]", "It's been a dictatorship", "We don't feel we can speak up", "The staff here sometimes aren't very dynamic", "Some staff are stirring things up," and, "There's back biting among seniors and care staff." One staff member told us meetings had been held to discuss morale and said, "The new management is holding meetings and trying to boost confidence but not a lot seems to have been done." Another staff member said that whilst they got on with the manager there were others in the team that did not pull their weight and team working was poor.

We were concerned about the potential impact this sentiment could have on the care and welfare of people using the service. A significant number of staff we spoke with told us they were thinking of leaving the

organisation due to these concerns which if followed through could lead to further staffing issues. A number of relatives told us they had picked up on problems with management and staff morale. One relative told us, "There are BUPA management issues. They haven't managed the leadership properly. There was a lack of clarity about the permanent appointment of the new manager; it didn't happen. It's not easy to communicate." They went on to say, "I am concerned about staff morale; there have been so many changes…management focus on marketing. They need to focus on staff morale." Another relative told us, "I can sometimes hear them…They say they are exhausted and I have heard them say they are not prepared to be bullied." However one person told us, "The staff morale and the atmosphere is excellent. They are all cheerful. I don't have a word against this place."

Supervisions which are a key mechanism for staff support were not up-to-date, for example some care staff had not had any formal supervision meetings such July 2016.

We found accurate records were not maintained in relation to some people's care and support. Medicine records did not always contain the number of tablets in stock meaning we were unable to account for all medicines. This increased the risk of misuse and did not provide a clear record of the support people were receiving. An accurate record of each service user's care was not always kept. Some people were on food and fluid charts to monitor their intake. We were concerned about the low amounts of fluids recorded for some people. For example, one person had only 220mls fluid recorded as taken in one day and 310mls another day. Another person had only 150mls recorded on one day. We looked at some people's food charts and saw some records had not been completed. For example, one person's chart was not recorded for 13 December 2016, only a record of their breakfast noted on 9 December and no food recorded since lunchtime on 19 December and 28 December. A member of staff told us charts were not always completed due to time constraints.

We also found a lack of audit and oversight of positioning charts and food and fluid charts to review people's care and support arrangements and ensure they were completed correctly.

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

A range of audits and checks were carried out. Daily clinical walkarounds were undertaken by the interim manager. These checked on how the home was operating, staffing levels, any incidents and accidents, safeguarding and any deterioration in people's health. These helped the interim manager monitor the quality of the service. Audits were also undertaken by staff at head office. These looked at a range of areas and provided staff with action plans to work to. For example, we saw a recent audit had been undertaken which looked at care plans and DoLS authorisations and an action plan had been sent to house managers for completion. Internal audits were undertaken by senior staff including care plan and medicine audits. Checks on the medicines system included a post medicines round review, weekly medicines audits and reviews of the use of anti-psychotic medicines. However due to discrepancies we noted with regards to the number of tablets in stock, we concluded more attention was required to audit of stock levels.

Staff meetings took place. These included weekly clinical meetings, as well as care staff meetings. These were an opportunity to discuss any quality issues to help improvement of the service.

Mechanisms were in place to seek and act on people's feedback. Periodic resident and relatives meetings were held and a 'Friends of Burley Hall' meeting where stakeholders could make suggestions for improvement within the home. A recent resident survey had been undertaken by the home and the results were in the process of being analysed in order to ascertain performance. The regional director told us once

the results were received, they would review the responses and determine how these could be used to improve the service. The service displayed a 'you said, we did' information board in the reception area which indicated actions taken as a result of peoples' previous comments and suggestions.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance (1) (2a) (2b) (2c) An accurate and complete record of each service users care was not kept. Systems to assess and monitor the quality of the service and risks to people's health and safety were not sufficiently robust.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing (1) Sufficient quantities of staff were not deployed within the service at all times