Four Seasons 2000 Limited

York Court

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Overall summary

We carried out an unannounced comprehensive inspection of this service on 19 and 20 January 2015. We found breaches of legal requirements relating to safeguarding people, staff support, person centred care, receiving and acting on complaints and good governance. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches identified.

We carried out a focused inspection on 9 June 2015 to check that they had followed their plan and to confirm that they now met legal requirements in relation to the more serious breaches that related to care and welfare. We found that some improvements had been made.

This inspection was carried out to check that the provider had met the legal requirements in relation to breaches related to safeguarding people, staffing, person centred care, receiving and acting on complaints and good governance.

Summary of findings

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

York Court provides accommodation, nursing and personal care for up to 59 older people over three floors. There were 38 people using the service when we visited. On the ground floor there is a mixed nursing unit, with some people who are living with dementia. On the first floor, there is a dementia unit and on the second floor a residential unit for people who are more independent.

There was a registered manager at the service; however he was not managing the service at the time of our inspection. A peripatetic manager was overseeing the management of the home. 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.

At this inspection, we found that improvements had been made in some areas but concerns remained with other aspects of care being delivered. Prior to the inspection we were informed that the home would be closing and staff would be offered redundancy. Arrangements were being made to find alternative suitable placements for people using the service and the provider was working with the local authority to facilitate this process.

Although people told us they felt safe, safeguarding procedures at the home were not always effective. There had been a number of safeguarding concerns at the home since our previous inspection which CQC had not been notified of and one of the concerns was identified and reported by a visiting healthcare professional.

People gave us mixed feedback about the quality of food. We found that people who were at risk of malnutrition and had food and fluid charts in place did not have their needs met. Staff did not complete these records in sufficient detail to enable people's needs to be met effectively. Other aspects of record keeping at the service were poor. Risk assessments did not always reflect people's changing needs and some care plans that had been developed were based on conflicting information in the risk assessments.

Some people at the service had restrictions placed upon them. The provider had not followed procedures and submitted applications to the local authority for these restrictions to be authorised formally.

Although staff received supervision and we found that staff numbers at the home were adequate to meet the needs of people, the high use of agency staff had an impact on the provision of care. Staff were not always familiar with people's needs and there were occasions where people were left without adequate support.

Regional and peripatetic managers were on site the majority of the time, overseeing the service and carrying out audits. However, we found that these were not always effective and actions were not always assigned for people to follow up which meant that we could not be assured that identified shortfalls would be addressed.

A number of service level concerns meetings had been held in relation to York court where concerns had been raised by the CCG and social services.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care, staffing, consent, meeting nutritional needs, safeguarding and good governance. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

We found that action had not been taken to improve the safety in this service.

Although people we spoke with told us they felt safe, the provider had not notified CQC of safeguarding concerns that were being investigated.

Risk assessments were not always reviewed regularly and did not reflect people's support needs.

There was an over reliance on agency staff who were unfamiliar with the needs of people using the service who on occasion were not able to support people in a way that kept them safe.

We could not improve the rating for safe from inadequate because sufficient improvements had not been made. We will complete another inspection to check that improvements have been made if the service does not close as planned.

Is the service effective?

Inadequate

We found that action had been taken to improve effectiveness in relation to staff supervision but there were concerns that people's nutritional needs were not being met.

Where people had been deprived of their liberty or had restrictions placed upon them, the provider had failed to follow the Mental Capacity Act 2005 and not requested formal authorisation for these restrictions.

Food and fluid charts in relation to people's nutritional needs were not always completed with a level of detail that was acceptable in order to continue to support them.

We could not improve the rating for effective from inadequate because sufficient improvements had not been made. We will complete another inspection to check that improvements have been made if the service does not close as planned.

Is the service caring?

Requires improvement

We found that action had been taken to improve caring at the home, however, there were still some aspects of the service that were not always caring.

We observed mixed interactions between staff and people using the service. Although some staff displayed a caring attitude there were occasions where people were left unattended for long periods.

Care plans did not reflect people's preferences and social history which would have enabled staff to care for them in a more personalised manner.

Summary of findings

We could not improve the rating for caring from requires improvement because sufficient improvements had not been made. We will complete another inspection to check that improvements have been made if the service does not close as planned.

Is the service responsive?

Inadequate 

We found that action had been taken to improve responsiveness.

Formal concerns that people had raised were responded to.

We could not improve the rating for responsive from inadequate because we did not see sufficient evidence to show that these improvements could be sustained. We will complete another inspection to check this during our next planned inspection if the service does not close as planned.

Is the service well-led?

Inadequate 

We found that action had not been taken to improve how well-led the service was.

Changes to the manager of the service had caused uncertainty amongst staff and people did not feel confident in the management of the home.

Although quality audits had been conducted, these were not always effective in picking up concerns and actions to improve the quality of the service and were not always sustained.

We could not improve the rating for well-led from inadequate because sufficient improvements had not been made. We will complete another inspection to check that improvements have been made if the service does not close as planned.

York Court

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of York Court on 29 September 2015. This inspection was carried out to check that improvements to meet legal requirements planned by the provider after our inspection on 19 and 20 January 2015 had been made.

This unannounced inspection was undertaken by an inspector, an inspection manager, an expert by experience and a specialist advisor. An expert by experience is a person who has personal

experience of using or caring for someone who uses services like this. On this inspection the specialist advisor was a nurse with extensive experience of caring for older people in a nursing home.

Before we visited the service we checked the information that we held about it, including notifications sent to us informing us of significant events that occurred at the service and safeguarding alerts raised.

During our inspection we spoke with eight people who use the service, five relatives and a friend of a person using the service. We also spoke with the peripatetic manager, two nurses, five care staff, two kitchen staff, the activities co-ordinator and a visiting healthcare professional. We made general observations on each of the floors and we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed eight care records and nutrition risks assessments, food and fluid charts for four people. We also reviewed records relating to the management of the service including incidents and accident records, complaints records, staff supervision records, training records and kitchen records in relation to people's dietary needs. After the inspection, the provider emailed us some samples of quality assurance audits they had undertaken. Both before and after the inspection, we attended a number of meetings with the local authority and the local clinical commissioning group to discuss concerns about the service and reviewed minutes of these meetings.

Inadequate

Is the service safe?

Our findings

At our previous inspection which took place on 19 and 20 January 2015, we found that the provider was not managing safeguarding concerns appropriately.

At this inspection, we found that the provider was still not managing safeguarding concerns appropriately and had failed to notify the Care Quality Commission about four safeguarding incidents that were in the process of being investigated. Prior to the inspection, we contacted the safeguarding team at the local authority who gave us details of the current safeguarding concerns at York Court. We found that we had not been notified of all these concerns when we cross referenced this information against the statutory notifications that had been sent to us. For example, there had been an allegation that an agency nurse was putting a medicine dispenser too far into the mouth of a service user, an allegation of assault, poor care of a suture injury, and an allegation of abuse. One of these safeguarding concerns had been reported by a visiting healthcare professional and not picked up by staff in the service. We spoke with the peripatetic manager about these concerns who told us they would send in the notifications immediately after the inspection. We had not received these notifications by the time the report was sent to the provider.

We could not be assured that the provider had effective systems in place to identify, manage and report safeguarding concerns. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All the people we spoke with told us they thought they were safe from harm, one person said “Nobody will bully me.” Staff were aware of what the term safeguarding meant and told us they would not hesitate to report any concerns. One staff member told us, “Safeguarding is protecting the residents. We need to keep them safe from injury and strangers.”

We reviewed a number of risk assessments during the inspection and we found that not all were fit for purpose. In one example, a waterlow assessment was used to give an estimated risk for the development of a pressure sore. The initial assessment had been completed in July 2014. This had been reviewed on a monthly basis on a separate page and the overall score had fluctuated between high and very high risk. However, the associated care plan that had been developed was based on a different score and therefore we could not be assured that the person’s individual needs were being met.

Some aspects of the care plans did not contain enough detail to ensure that risks to individuals were managed. For example, one person had a nutrition plan which stated '[person’s] blood sugar to be checked at least...', but there was no guidance on the expected frequency of the blood sugar monitoring tests. In another example, a person was assessed as being at high risk of falls, but their mobility care plan stated that the person's needs were medium risk.

People’s behaviour that challenged was not always managed in a way that maintained their safety and protected their rights. Care plans in relation to behaviour that challenged, mental health and cognition need did not provide sufficient guidance for staff. This was especially the case for people with dementia. The information in the plans did not always provide sufficient guidance for staff. For example, one person’s care plan stated that they often did not allow staff to carry out the care and support outlined in their care plan but did not provide specific details about how staff should manage or respond to this in the best interests of the person and to ensure a consistent approach.

Two service users were assessed as having a number of challenging behaviours including aggression, absconding and making allegations. However, on examining the care files there were no clear behaviour management plans in place or guidance to enable staff to manage these behaviours.

The above identified issues were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was extensive use of agency staff as a result of staff leaving and a freeze on recruitment and the imminent closure of the home. This resulted in a lack of continuity of care as staff were not familiar with people’s individual needs. The peripatetic manager who was overseeing the closure of the service told us staffing levels were being reduced as people moved out of the service but said this was being managed to ensure there were enough staff on duty to meet people’s needs.

However, despite adequate numbers of staff, the frequent changes of staff who were unfamiliar with people’s

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Is the service safe?

individual needs meant that people were at risk of not having their needs met. For example, when asked, two members of staff were unable to tell us about individual people's needs and advised us to ask a permanent member of staff. One staff member said, "It's a bit unstable here in terms of staffing."

We also found that people's needs were not met in a timely way. For example, one person told us that, "The staff are very nice but I have to wait a long time if I need someone." Another person told us that they stayed in their room because they needed support to walk but, "The staff haven't got time." One person said they had been left in bed until 11 o'clock one morning recently. They went to explain that the care workers were very busy in the mornings and since they were unable to dress independently, they had to wait. A relative told us that the care workers do their best but they didn't think the overall care was very good. They said there were too many agency staff now and her family member did not know them.

In addition, we observed that one person was left sitting at the table, sleeping with their head on the table in an uncomfortable position and staff did not support this person to ensure they were made more comfortable or taken to their room so they could sleep as they were busy supporting other people with their meals.

We observed an agency care worker having difficulty getting support from other care workers with one person. The call bell was used because the person needed two care workers to support them with personal care. This went unanswered for 15 minutes until the Head of Department responded then went away having told the agency care worker they were going to bring someone to help. Another five minutes passed and no one arrived until the inspector went and requested a second care worker to assist.

A number of concerns were raised during service levels concern meetings regarding the high use of agency staff. At the time of our inspection, there were only two permanent nurses in employment. The remaining nurses were being supplied by an agency. The provider acknowledged that they were reliant on agency staff to cover shifts at the home but told us they had tried to minimise the effects of this by trying to retain agency staff that were familiar with the service and giving incentives to permanent staff to cover shifts by offering higher rates of pay if they worked beyond their contracted hours.

We found the above issues to be a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

At our previous inspection which took place on 19 and 20 January 2015, we found that staff were not adequately supported to carry out their roles. Staff appraisals and supervisions were not taking place to ensure that they received adequate management support to carry out their roles effectively.

At this inspection, we found that some improvements had been made.

We noted that there was an induction checklist for agency staff. However, staff informed us that they had been asked to start work with little or no information about the service or the people they were caring for. We noted this during our observations of lunch when an agency member of staff had no knowledge of the support a person required and struggled to assist the person with their lunch. They did ask another member of staff but it would have been more appropriate if the staff member had been told about this person's needs before being asked to assist them.

Staff had received supervision and the opportunity to discuss their work and any development needs. We noted that where there were staff performance issues these were recorded and expectations made clear. However, there was limited evidence that these issues had then been followed up to ensure that staff were effective in their role. We did not see any evidence of annual appraisals. The manager overseeing the closure of the service told us that these were unlikely to be completed due to the planned closure of the service.

Mandatory staff training was available in a range of areas including moving and handling, infection control, food safety and safeguarding. We also saw that some staff had been supported to complete training on a person centred approach to caring for people with dementia. Staff accessed most training via an online e-learning system. A central record was kept by the provider so that training could be monitored and refreshed as required. There were some gaps in the training records due to the lack of permanent staff and staff changes at the service. The manager told us that training was no longer a priority as the service was being closed.

The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make certain decisions for themselves and to ensure decisions are made in people's best interests. DoLS are part of this legislation and they make sure that where a person may be deprived of their liberty, for their own protection or that of others the least restrictive option is taken. The Care Quality Commission (CQC) is required by law to monitor how care homes operate the Deprivation of Liberty Safeguards (DoLS) and to report on what we find.

There was limited information within the care documentation examined to demonstrate that consent to care and treatment had been obtained by the people using the service or their representatives where appropriate. None of the care plans examined showed evidence that they had been agreed and completed in conjunction with people using the service or their representatives. Every care record that we examined had a section entitled 'Rights, consent and capacity'. These sections were not always completed fully and had limited information regarding consent.

Mental capacity assessment plans were in place in all the care records that we looked at but these documents did not appear to be fully completed and provided limited information regarding how the assessments had been completed and the outcome of the assessments. For example, one person who used the service, had been assessed as not being able to make 'simple, non-complex decisions'. There was no explanation about the assessment process and how this judgement had been arrived at.

In one person's care files, details about consent were recorded and had been reviewed as recently as 13 September 2015. There was a consent form in place for the use of bed rails and a lap belt which had been discussed with their next of kin as the person was not able to give valid consent due to their dementia, however it was not clear if a formal best interests meeting had been held in relation to this decision making process in line with the MCA.

We spoke with the peripatetic manager during the inspection regarding applications for DoLS where it was deemed that people were being restricted. They told us they were in consultation with the local authority regarding these and would be submitting 14 DoLS applications in the days following our inspection for people that were not able to move within or go out of the home due to keypads on exit doors.

Inadequate

Is the service effective?

We found that staff had limited knowledge of the MCA and DoLS and could not tell us what their responsibilities were in relation to protecting people's rights. One care worker said, "I'm not sure what a DoLS is."

We found the above issues to be a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we spoke with a training chef who was working with kitchen staff around creative ways of presenting soft and puréed diets and providing fortified meals. He was also looking at food hygiene and kitchen safety. He said that staff were keen to improve the way they did things but said they required training and mentoring to be able to achieve this. He said that the kitchen staff were not always updated about changes in people's dietary needs in a timely way which could lead to people's needs not being met.

We spoke to a member of kitchen staff who showed us records that identified people who had special dietary requirements. The member of staff commented that communication between care staff and the kitchen had been poor in relation to keeping them updated about people's individual needs but said this had improved recently.

We looked at food and fluid intake charts for those people who were at risk of malnutrition. We found that there were gaps in these and therefore could not be assured that people's nutritional needs were being met. For example, amounts of food eaten were not always recorded and there were blank records which indicated that people had not had anything to eat or drink for long periods of time. We also found that people's care plans did not accurately record their nutritional needs. For example, one person's care plan stated that a puréeed diet was required but did not mention that this person's meals should be fortified as they were at risk of malnutrition. In addition, the daily records for three people who were at risk from poor nutrition stated that these people had 'ate and drank well' despite their food and fluid charts stating something contradictory to this.

We asked a member of staff about how they would ensure that one person who had been asleep during the whole of the lunchtime period would get enough to eat. They answered, "Tea and biscuits or cake will be offered this afternoon." However, the staff member was unaware that this person's care plan advised that they should be encouraged to drink at least one litre a day or that they had diabetes.

We spoke with a visiting speech and language therapist (SALT) during our inspection. They told us that they were visiting to follow up on the support provided to two people living at the service. They commented that records in relation to one person on the first floor who they had last visited on 3 September 2015 had not been updated and it was unclear what progress the person was making or how they were managing following guidance given to staff at the last visit. The SALT said the records stated that the person had 'ate and drank well' which did not provide enough information for her to make an assessment about how the person had managed since changes to their diet had been made following her last visit.

The issues above meant that we could not be assured that the provider was effectively meeting the nutritional needs of people using the service. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed some good interactions on the second floor during lunchtime. Staff encouraged people to eat and we saw one example where a person was slightly hesitant, a care worker kept an eye on them, repeatedly going over to encourage her to eat a little more. Slowly this person began to eat. People did finish their food and one person who didn't like the pudding they were offered was given an alternative of fruit yogurt. One relative told us that their family member was now eating more since they had come to live in the home.

Requires improvement

Is the service caring?

Our findings

At our previous inspection which took place on 19 and 20 January 2015, we found that staff behaviour was sometimes uncaring and not respectful of people using the service.

At this inspection, we found that some improvements had been made although the high use of agency staff meant that there was unfamiliarity between staff and people and using the service. This was evident in some of the interactions we observed. We also saw mixed interactions between staff and people, some positive and some negative.

We observed lunch in the dementia care unit and found that people's dietary needs were not always met effectively. For example, we noted that two people who required prompting to eat their meal were not prompted regularly to ensure they received enough to eat. This also meant that their meal was left to go cold. In addition we noted that one member of staff did not know how to support the person they were assisting and therefore struggled to encourage the person to eat.

One person who was sitting in her chair was moved forward by staff to allow them to pass behind them without telling them first. In another incident, we observed a member of staff attempting to put socks onto one person even though this was distressing the person and they cried out. They carried on with this until another staff member told them to stop.

We also did an observation on the residential unit on the second floor during lunchtime, which was more positive. People had a drink of squash and the tables were set with cutlery, condiments and table mats. Two care workers attended to the people, they were very cheerful, chatty and people smiled at them. It was clear they both knew the people they were supporting. They went to each person, asking their choice of meal and then served it from the trolley. The activities co-ordinator and one of the kitchen staff also came to have their lunch in this dining room. The atmosphere was very friendly. They were joined by a person who had a room on the ground floor who was brought up in the lift by her friend. It was explained to us that they enjoyed having their lunch on the top floor because they knew some of the other people.

People were not that enthused by the activities on offer at the home, although they did praise the activities co-ordinator. There was only one activities co-ordinator employed, there had previously been a part time activities co-ordinator but they had not been replaced after leaving their post. Two people told us that the quizzes were too easy for them. There was the occasional game of dominoes but one person told us they found it frustrating that many of the people didn't know how to play and said there was very little else to do. One relative told us that their family member had been taken into the lounge to watch a clown perform but the experience had upset them because the atmosphere was very loud, noisy and frenzied. They had told the staff that they must ask their family member in future about the types of activities they wanted to participate in.

We did an observation during an activity in the lounge before lunchtime. There were nine people in the room and one activities co-ordinator. Two people were taking part in an arts and crafts activity and a third person was flicking through a magazine. The focus was on the two people that were doing arts and crafts whilst the rest were not engaged; this in part was due to a lack of support from other staff. It was clear that the activities co-ordinator struggled to engage with the number of people in the lounge. One person was falling asleep on her chair and looked uncomfortable with her head drooping. She was left in this position for 30 minutes and staff attended to them when this was highlighted by the inspector.

Care plans were separated into 12 sections covering key aspects of care. Overall, care records did not provide a person-centred approach with minimal detail about the person, the way they like to be supported, their interests, likes, dislikes and social histories. Records did not present a clear description of the person's past social histories so that staff had information to enable them to provide support that met each individual's needs and preferences.

All care files contained a document called 'This is me'. In the examples examined this document had been completed, but focussed on care needs rather than social background, personal preferences and other choices. In all cases this document was not dated, therefore it was not possible to establish how current the information was. There was no clear evidence that this document had been reviewed or updated. One file contained a newly developed document addressing the person's choices and other

Requires improvement

Is the service caring?

background information. This document had not been completed and was filed at the back of the individual's folder. A senior member of care staff stated, "'We have six hours to write a care plan when someone is admitted to the service. There is too much documentation, so we didn't have time to complete this." The staff member was asked why this document was filed at the back of the folder and they replied "That is the order we have to make the files up in. That is how we were told to do it."

The peripatetic manager told us there was a plan in place to review the care plans but this had been stopped following the decision to close the home.

People told us they were supported to maintain their independence. We observed a care worker verbally supporting a person move from their wheelchair to a lounge chair. The staff member stood close by and encouraged the person to independently change seats. People told us they chose when they went to bed each evening. One person said they got the opportunity to visit the library to change their books or borrow a different DVD. A relative said they were appreciative that the staff allowed their family member to help lay the tables and do some gardening every now and again.

Inadequate

Is the service responsive?

Our findings

At our previous inspection which took place on 19 and 20 January 2015, were not managed and responded to appropriately to ensure that issues were satisfactorily resolved.

At this inspection, we found that some improvements had been made.

During this inspection we found that complaints had been investigated and responded to in a timely way. The complaints log showed detailed correspondence with complainants at different stages of the investigation to keep people informed. People told us they knew how to make a complaint but had mixed views about whether they thought things would change as a result of raising concerns. For example, one person said, “They listen but they don’t always do anything.” Another person said, “They would do something to help.” Written information about how to make a complaint was available.

Although we found that serious concerns had been addressed, work was still in progress and sufficient time had not passed to assure us that these improvements could be sustained. Therefore we have been unable to change the rating for this question. A further inspection will

be planned to check if improvements have been sustained if the service does not close as planned.

Inadequate

Is the service well-led?

Our findings

At our previous inspection which took place on 19 and 20 January 2015, we found that there was an absence of effective quality monitoring and auditing to ensure that any shortfalls were identified and addressed.

At this inspection, we found that there were still some concerns.

A few weeks prior to the inspection we were advised that the service would be closing. Since the previous comprehensive inspection there had been a number of managers, deputies and peripatetic managers overseeing the management of the home which had led to uncertainty amongst people using the service, relatives and staff.

Most of the people we spoke with had little idea who was managing the service. One person explained that the manager was always downstairs and as they needed a care worker to help them get to the ground floor they had not seen the current manager. Another person laughed when they were asked about the manager, they said that this was the, "Eighth" since they had been in the home. A visitor said that they could think of nothing positive to say about the management of the home.

There was evidence of a lack of leadership in the service. There had been six managers over the last two years and this had had a significant impact on the service. For example, there was little direction for staff and expectations were not clear. Staff told us they did not feel fully supported by the management team at the home. Staff said, "I do what I need to do, I don't worry too much about the managers", "I'm concerned about what's going on and what's not going on" and "We are always kept out of the loop."

Other staff comments included, "If the manager leaves then you don't always hear about it, you hear it from gossip", "It's unsettling", "They don't keep us up to date", "We weren't officially told that [the previous manager] left" and "The nurse on the unit today is agency, I've never met her before." The lack of leadership was particularly evident on the first floor where we found that staff were not clear about what they should be doing and did not fully understand the needs of the individuals they were supporting.

Staff that we spoke with were not fully aware of who to report issues to in terms of day to day management and staff on the first floor told us that because of a lack of permanent staff on the floor they usually approached the head of unit on the second floor about any concerns. Throughout the inspection, we observed the head of unit on the second floor come down to the first floor to make sure things were OK. The head of unit was not a registered nurse but a senior care worker. The nurse in charge on the day of our inspection was an agency nurse who was on their first full day at York Court. They told us they had previously worked a half day on the unit. They told us they were not familiar with the people on the unit and their duty was to ensure the people's nursing needs were being met for the duration of the shift.

Staff said they did not have regular staff meetings and the peripatetic manager was not able to produce any recorded minutes for any staff meetings that had been held recently. One staff member said, "We don't have regular staff meetings."

Regional and quality managers had been deployed to the service to monitor the quality of service but it was hard to tell if any of their visits had resulted in any improvements. The peripatetic manager was unable to produce any quality assurance audits apart from a print out of the incidents and accidents at the home and a record of complaints, both recorded on the provider's online system.

There was little evidence that nursing audits were consistently carried out and that the information from this feedback was used to inform best practice and assessments of risk. One senior member of care staff stated that incidents and accidents were reported online. However, they stated that this information was not reviewed by the care team. They said that once the information was inputted into the system staff were not involved in the review of incidents to establish themes, trends and antecedents.

Records of falls and pressure sores on one floor were examined, but these had not been completed since August 2015. The records only demonstrated the number of falls and pressure sores, but did not show any analysis of this information to inform improvements to the service.

New care documentation had been introduced by the providers, but this did not appear to have been implemented consistently with a range of forms in use and

Is the service well-led?

variations between floors regarding the use of old and new forms. For example, one person's daily notes were being completed on two different forms therefore not providing a chronological record of care provided. The peripatetic manager told us that although work had started to transfer existing care plans into new records that were more person-centred, this had been put on hold due to the impending closure of the service.

Following the inspection, the provider emailed us some examples of the quality audits they had been carrying out at the service. These included 'walkarounds' checking the home, staff attitude, people being cared for, clinical records and care plans. There were three possible findings against each of these, 'Good', 'Not so good, but fixed' and 'Not so good'. These checks were limited in their scope and did not provide evidence as to which records had been checked, or which people were spoken with. They did not identify what action had been taken if issues were identified, for example there was one entry which stated 'missing entries not being completed immediately' when it was found that clinical records had not been completed correctly. It was not possible to tell who's records were not completed correctly and what action had been taken in response to this. There was another entry which stated, 'Noted stains to carpet on first floor, along with dried food on settee. Beds not made.' There was no identifiable action that was taken in response to this.

Comprehensive reviews were also carried out for people using the service. We found that where issues were identified, it was not always clear if actions to correct these issues were assigned to staff. For example, we saw entries such as 'Dependency levels have been recorded incorrectly and identify medium dependency when it should be high', 'The resident's pre admission assessment has been completed, however it does not clearly identify the risks and challenges to providing good and safe care', 'Unable to locate the document in the care documentation'. It was not clear what action had been taken in response to these findings.

A regional manager's audit carried out on 25 August 2015 identified issues with the quality monitoring at the home. For example, the expectation to review one person's records per week was not being done, the quality dining audit and resident feedback on food was also 'not consistently' received.

We attended a number of service level concerns meetings chaired by the local authority and attended by a number of stakeholders including the CCG, social care teams and safeguarding teams. A team of nurse observers had been attending York Court to observe care and work with the staff at York Court to ensure people's needs were being met. During the course of these meetings concerns were raised by the CCG about the provision of care in relation to high use of agency staff and poor record keeping.

We also reviewed minutes from a safeguarding meeting that had been held in July 2015 in which an allegation of neglect was substantiated. One of the recommendations from the meeting was for a 'lead nurse to take ownership of safeguarding issues raised and deal with them promptly.' This was not in place at the time of our inspection.

We found the above issues to be a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

'Colleague engagement surveys', were completed which were feedback surveys carried out for staff. Weekly medication audits were carried out. We saw one instance where previous actions were followed up and the recorded entry was 'Unable to access previous audits'.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The provider did not assess or effectively mitigate the risks to the health and safety of service users in relation to care or treatment. Regulation 12 (2) (a) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Sufficient numbers of suitably qualified, competent, and experienced persons were not deployed. Regulation 18 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: The registered person did not act in accordance with the Mental capacity 2005 Act where service users did not have the capacity to consent to care and treatment. Regulation 11 (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs How the regulation was not being met: The nutritional and hydration needs of service users were not being met. Regulation 14 (1).

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: Systems and processes were not operated effectively to prevent abuse of service users. Regulation 13 (2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems and processes to assess, monitor and improve the quality and safety of services provided were not operated effectively. Regulation 17 (2) (a).

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems and processes to assess, monitor and improve the quality and safety of services provided were not operated effectively. Regulation 17 (2) (a).

The enforcement action we took:
We have issued a warning notice to York Court in respect of this regulation.