Burlington Care (Yorkshire) Limited

Crystal Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 30 October and 7 November 2018. The first day of the inspection was unannounced.

Crystal Court is situated in Harrogate and is registered to provide residential and nursing care for up to 60 people some of whom may be living with a physical disability or dementia. The service is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Accommodation was provided within one building which was separated into three units where people lived according to their specialist needs. People had their own room, access to large communal spaces and outdoor space. At the time of our inspection there were 48 people living at the service.

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 the time of our inspection a registered manager was not in post. The provider informed us the position had been offered to a person and they were awaiting confirmation of their start date. The business manager, with oversight from the regional manager, was managing the service on a day-to-day basis in the interim period.

Staff were not effectively deployed to meet people's needs in a timely manner. Staff and people who used the service expressed their concern to us about staffing levels. Staff worked in a task centred way and did not spend enough quality time with people outside of planned activities.

Although staff had received moving and handling training, we observed the use of poor moving and handling techniques during our first day at the service. We highlighted this to the provider who took appropriate actions by the second day of our inspection.

Inductions for new members of staff were not monitored to ensure they were making sufficient progress within their role. Probationary reviews were not completed to ensure people were happy within their role and to discuss any additional learning needs. Staff undertook training the provider considered mandatory. However, training specific to the needs of the people who used the service was not in place.

Risk assessments and care plans did not consistently contain up to date information about people's needs. Reviews of people's support were completed on a regular basis but they did not demonstrate people's involvement in their support.

The provider had a programme of quality assurance checks to monitor the safety and quality of the service

provided. The checks had not consistently highlighted the issues we found during our inspection. This increased the potential risk to people and resulted in shortfalls in governance.

People told us they received their medicines as needed and staff undertook training to ensure they had the necessary skills and knowledge. However, there were gaps within some people's medicine administration records and best practice in relation to the recording of medicines administration was not consistently followed.

We have made a recommendation about the implementation of best practice guidance in relation to the management of medicines.

Staff undertook safeguarding training and were aware of potential signs of abuse and who to report their concerns to. Staff continued to be recruited in a safe manner. The home was clean and there were no malodours and staff understood the actions to take to prevent and control the spread of infection.

Mental capacity assessments were not consistently completed when a person was thought to lack understanding in relation to a part of their lives.

We have made a recommendation about ensuring understanding and adherence to the Mental Capacity Act.

Feedback about the quality of the food was generally positive, but some people felt there could be a better variety of food available. We observed the dining experience for people varied, however the food smelt appetising and was nicely presented.

There were inconsistencies in staffs' approach towards people. Some people told us staff were kind and treated them with respect and dignity. Others described how staff were not always gentle with them during personal care and felt some staff could be abrupt. We observed some warm interactions between staff and people who used the service. Staff spoke about people in a respectful manner and ensured people's dignity and privacy was promoted.

A programme of activities was available to people but there were extensive periods of time where people did not have access to any opportunities for stimulation. Records did not demonstrate people had regular access to activities that were centred around their own personal needs and interests.

We have made a recommendation about ensuring people receive person-centred care.

People's feedback had been sought about the running of the service. The most recent questionnaires were awaiting analysis by the provider. The questionnaires reviewed showed that whilst people were generally happy with the standard of care, there were some areas which could be improved including the answering of call bells and activities. Concerns raised through resident's meetings were not consistently addressed or used to improve the quality of the service.

A series of meetings were held with staff and the people who lived at the home, to share important information about the running of the service.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to staffing and the governance of the service. You can see what action we told the provider to take at the back of the full version of this 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 always safe.

Sufficient numbers of staff were not always deployed and some unsafe moving and handling techniques were observed.

Risk assessments did not consistently contain up-to-date detailed information to guide staff.

Improvements were required to the recording of medicines administrations.

Staff completed safeguarding training and understood signs of abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received mandatory training but had not received specialist training according to the needs of people who used the service.

The induction for new staff was not monitored to ensure they had the knowledge and skills for their role.

People had access to healthcare professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

There were inconsistencies in the way staff approached people.

People were not routinely encouraged to make their own day to day choices.

People had access to independent advocacy services.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a lack of activities and stimulation for people.

Care plans were in place but did not always contain up-to-date information.

Information relating to people's end of life wishes was in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Concerns raised about staffing levels had not been addressed by the provider.

Although feedback was sought about the running of the service this was not used to improve the quality of the service delivered.

Quality assurance process had not consistently identified areas where improvements were required.

Crystal 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 was 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.

The inspection took place on 30 October and 7 November 2018. The first day of the inspection was unannounced. The inspection was carried out by four inspectors, a specialist advisor with a background in medicines and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience who supported this inspection had a background of supporting people living with dementia.

Before our inspection we reviewed information we held about the service, which included information shared with the CQC and statutory notifications sent to us since our last inspection. The provider is legally required to send notifications about events, incidents or changes that occur and which affect their service or the people who use it.

We also considered the Provider Information Return. This is information we require providers send us at least once annually to give key information about the service, what the service does well and any improvements they plan to make. We sought feedback from the local authority and Healthwatch. Healthwatch is an independent consumer group who share the views and experiences of people using health and social care services in England. We used all of this information to plan our inspection.

During the inspection we spoke with five people who used the service and five relatives of people who used the service. We spoke with eleven members of staff which included the managing director, business manager, area manager, cook, activities coordinator, nurses and care assistants. We received feedback from two visiting health and social care professionals. We had a tour of the building and looked into people's bedrooms, with their permission. We spent time observing interactions in communal areas which included observing the lunchtime experience.

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 three staff files, which contained information about training, supervisions and appraisals. We looked at documentation for seven people who used the service, which included care plans, risk assessments and daily records. We reviewed the medicines management systems and a variety of documentation relating to the running of the service.

Requires Improvement

Is the service safe?

Our findings

Staffing levels were generally safe however the deployment of staff required improvement, particularly at night time, to ensure people's needs were met in a timely manner.

A dependency tool was used to assess the minimum staffing levels required to safely meet people's needs. On two of the three units, staffing levels were higher than those deemed as required through the dependency tool. However, for the unit specialising in dementia care, staffing hours were 14 hours per week lower than required. There was only one member of staff based on this unit during the night. The provider advised that staff from the different units worked together to ensure people's needs were met. However, the rotas we reviewed showed that staffing levels were inconsistent. For example, the target for night staffing levels was two nurses and five care staff. The rotas showed there were nine occasions, within the last four weeks, where there were only six night staff. This would, therefore, impact on their availability to support other members of the team.

Staff expressed their significant concerns to us about the night staffing levels. A staff member told us, "I don't think people are safe at night. As we're not running at full occupancy staffing has been reduced. This not only affects staff but penalises the people who live here." Another staff member stated, "I think on the dementia residential unit you would say no, staffing levels aren't safe. You can't be everywhere at once and you feel totally unsupported." Staff referred to an incident whereby a person was unsettled and urinated in different parts of the unit including in another person's bedroom. The staff were unable to redirect or support the person as they were already supporting another person. Concerns around staffing levels on this unit had previously been raised during heads of department meetings and in a recent residents meeting. A person who used the service told the attendees, 'Sometimes at night I have one male and one female carer, and I'm meant to have two females and they have to do this sometimes because they can't swap with others upstairs because there is only one person on the residential unit. I feel like my wishes aren't being met.' No follow-up actions had been taken following the concerns raised within these meetings.

We received mixed feedback about staffing levels from people who used the service, however most people felt staffing levels were not sufficient. A person told us, "I have a call bell within reach but it takes them quite a while to come. They say they are busy, at night it is worse. I have to ring and ring it." Another person stated, "When I first came here in there was more staff. I would like to be able to have more chats with them but there isn't time, they are too busy." Questionnaires had been given to people who used the service and their relatives for feedback about the service. Whilst people generally felt the care provided to them was of a good standard we saw further comments relating to staffing. These included, 'There are often not enough staff on duty' and 'not always enough staff to deal with everyone's needs at the same time'.

During our inspection staff responded to people's call bells in a timely manner and attended to their basic needs but worked in a task centred way. Staff talked with people whilst they provided support but did not sit with them or engage in stimulating activities outside of the planned activities organised. Staff told us staffing levels were safe during the day but described having limited time to spend with people. Improvements were needed around the deployment of staff during the day. For example, a person whose risk assessment

identified the need for staff supervision when they were out of their bed, was left alone for long periods of time within a communal area. We immediately alerted staff as this person was observed leaning over their wheelchair and was at risk of harm.

The failure to ensure sufficient numbers of staff were deployed to meet people's needs was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they received their medicines as required. However, there were areas where improvements could be made with regards to the storage and recording of medicines. There were gaps on some people's Medication Administration Records (MAR) which meant we could not be sure people had received their medicines as required. Handwritten entries on the MAR had not been consistently countersigned in line with best practice and the amount of medicine received or carried forward was not always recorded. The label on a jar of thickening powder, which is added to fluids to help prevent choking, had been partly torn off and there were two medicines where part of the labelled instructions had been crossed off. This prevented the staff from adequately checking the prescribing information. The 'use by date' was not recorded on liquids once opened to ensure they were used within the recommended period of time.

Staff received appropriate training to ensure they had the skills to administer medicines and their competency was assessed. Staff had access to policies and procedures on the management of medicines and up to date reference sources. Appropriate records were kept of the ordering, receipt and disposal of medicines. Temperature checks for the rooms and fridges where medicines were stored were taken to ensure these were within the safe range, but there were some gaps in the records.

We recommend the provider implements best practice guidance relating to the management and recording of the support provided with people's medicines.

Whilst risk assessments were completed for most areas of identified risks, some had not been properly completed and did not contain up to date and detailed information to guide staff. For example, a person was identified as being at risk of falls and there was no information recorded about what actions staff needed to take to respond to and mitigate this risk. For another person, their moving and handling risk assessment referred to equipment which was no longer safe for them to use. We highlighted this to the provider and between the first and second day of our inspection, efforts were made to update the documentation.

On the first day of our inspection, call bells were not consistently within people's reach to enable them to alert for assistance if required. We notified the provider who requested staff checked each person's call bells. Checks of the condition of people's bed rails were not being completed to ensure these were in safe working order. The provider advised these would be introduced following our inspection. All other checks of the safety of the building and equipment were completed. Regular fire drills were arranged to ensure staff understood what actions to take in the event of a fire. Checks of the fire equipment were undertaken and information was available about the support people would need in the event of an emergency.

Despite the feedback about staffing levels, people who used the service and their relatives told us they felt safe. Comments included, "I usually feel safe because I see the same people" and "We have no concerns when we go away and have absolute confidence in everyone."

Recruitment practices continued to be safe. New staff completed an application form, had an interview, provided references and had a Disclosure and Barring Service (DBS) check. DBS check people's criminal records to help employers make safer recruitment decisions.

Agency staff were used when staff were absent. Agency profiles were in place to demonstrate agency staff had the necessary checks and training to safely support people. An induction was completed to ensure they were familiar with the layout of the building, key policies and procedures and the needs of the people they would be supporting.

Staff understood potential signs of abuse and who they would report their concerns to. The provider had a safeguarding policy in place and staff undertook safeguarding training which was refreshed to ensure their continued understanding in this area.

Accidents and incidents were recorded and information relating to these was sent to the provider for their overview. This system enabled the provider to monitor for any patterns or trends within the service.

We observed the building was clean and smelt fresh. People were generally positive about the standard of cleanliness in the building and told us, "My room is always cleaned on a morning and it never smells." Personal Protective Equipment (PPE) was available which staff used appropriately and staff understood what actions were required to prevent and control the spread of infection.

Requires Improvement

Is the service effective?

Our findings

The staff team received moving and handling training, however we observed some using poor techniques which could have caused people harm. A person was lifted from underneath their arms when they transferred into a dining room chair. The staff did not ask the person whether they were ready to transfer or comfortable once they had been seated. We later observed this person being transferred with equipment which was not adjusted to ensure their safety or comfort. People were not routinely offered the support to transfer from their wheelchairs into more comfortable chairs for meals or leisure time.

Staff undertook training the provider considered mandatory. This included safeguarding, health and safety and fire safety. Training specific to the needs of the people who used the service had not been consistently arranged. For example, a person who used the service had learning disabilities and mental health difficulties and staff had not received training to support their specialist needs. Staff had also not undertaken positive behaviour support. Positive behaviour support is a person-centred approach to supporting people who may become anxious or display behaviours that can challenge. The provider advised they were aware of some gaps within training and these courses had been requested.

Staff confirmed they had an induction which included training and shadowing other staff members. We were advised that staff new to the care sector undertook the Care Certificate in line with best practice. The Care Certificate sets out learning outcomes, competencies and the standards of care expected and is completed over a 12 week period. However, there was no recorded induction within any of the staff files we reviewed. The provider informed us people's induction records were with the staff themselves and not stored in the building. This prevented the provider from reviewing people's induction records to ensure they had undertaken the necessary training and had the required knowledge for their role. New staff had not received probationary meetings or supervisions to discuss whether they were enjoying their role or any additional support or training they required.

The provider acknowledged that probationary meetings and inductions should have been completed and reviewed by a member of the management team and confirmed these will be in future.

The failure to ensure staff are suitably skilled and competent was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We shared our concerns about the moving and handling of people with the provider. On the second day of our inspection, we were advised the provider had started assessing some staff member's moving and handling competency and all staff would complete moving and handling refresher training. The provider confirmed staff were reminded of the importance of ensuring people did not remain sitting in their wheelchairs for long periods of time, unless through their personal choice.

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.

Whilst some capacity assessments and associated best interest decisions had been recorded when a person was thought to lack understanding, these were not always in place. When capacity assessments had been completed the records did not demonstrate understanding of the principles of the MCA, such as consulting people close to the person. Staff's understanding of the principles of the MCA was also variable. The provider advised they had identified documentation was not sufficient and training had been arranged to aid staff's understanding.

We recommend the service refer to legislative guidance and develop staff understanding to ensure adherence to this piece of legislation.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. Applications to deprive people of their liberty were sought and monitored appropriately.

Most staff sought people's consent before providing care. We heard staff explain to people what they were doing and waiting for the person's agreement. A member of staff explained to us how they sought people's consent, "We have to read body language, make sure people can hear or write things down for people. We have picture cards we use to show people what we want to do so they can agree or not." Signed consent forms to show the person agreed with the contents of their care plan and the sharing of information were not consistently in place.

Staff received supervisions from a delegated supervisor. The provider's policy stated staff should have six supervisions annually, which could be in the form of one to one meetings or a team supervision. Whilst most staff had received a supervision within the last three months, others had not received a formal supervision since February 2018. Staff had received or were in the process of receiving annual appraisals of their performance. Staff told us they felt confident to raise any issues or concerns with their seniors.

Staff attended handovers to provide any updates and to share important information about a person's presentation or any appointments for the day. A handover document was in place which provided essential information about the people who used the service. However, we found for one of the unit's this document was not up to date. For example, one person was noted to have an allergy to fish. We saw the person being offered fish for their meal and alerted staff to their allergy. We were told by the staff member that the person's family had confirmed they did not have an allergy. The person's records confirmed this. The provider updated this document between the first and second day of our inspection.

People were generally positive about staff's understanding of people's needs. A relative told us, "The nurses and carers work on either floor; they know all the people, all the relatives and the carers. If there is a crisis or emergency and somebody is away sick they can seamlessly carry on without any problems in arranging for the right type of person to be available. Seamless ability to look after everybody which I think is worth noting."

Hospital passport documents were completed and contained information about people's needs should

their care transfer to a different environment.

People had access to healthcare professionals and staff sought professional's advice and input.

Records showed people were weighed on a regular basis and for most people their weight was stable. However, for one person they had lost a significant amount of weight and their nutritional risk assessment had not been properly completed to reflect this. The provider updated this between day one and two of our inspection and advice was sought from the relevant health professional. The provider also reviewed everybody's nutritional risk assessment tool to ensure these had been properly completed and the relevant referrals made.

We received generally positive feedback about the food and we found the food smelt appetising and was nicely presented. A relative told us, "[Relative] cleans their plate up so it must be good. They have a good appetite." Some people felt there was a lack of variation, particularly for the evening meal.

We observed the lunchtime experience within two of the units and found the quality of these experiences were variable. In one of the units, it was calm with a hum of conversation between staff and people who used the service. In another unit, the mealtime was disorganised. We also observed a person was being encouraged to eat food that was not of a safe consistency for them to eat. We immediately highlighted this to the staff member and provider. Following the first day of our inspection, information was available within each unit about suitable foods for different textured diets. The provider had also liaised with the Speech and Language Team and Dietician to request additional training around people's nutritional needs and online training had been arranged as an interim measure.

Communal areas were well furnished and people's rooms were comfortable. People had furnished their rooms with items of their choosing to help the environment feel homelier for them. The needs of people who were living with dementia were considered in the decoration of the environment. There was signage to guide people as to where bathrooms and toilets were and pictures on people's bedroom doors to orientate them to their own rooms.

Requires Improvement

Is the service caring?

Our findings

We received mixed feedback about staffs' approach to people. A relative told us, "They're all equally good and also this quality of staff is not just the nurses and carers, it's the domestics. There are always two cleaners and domestics. Whenever I'm here, they're here and they know all the residents and they will talk to the residents. If people want the television channel changing or go through some magazines, they will help them." A person who used the service said, "The staff are kind and polite. You do have your favourites but they all treat me well." At a recent resident's meeting a person said, 'The staff are very caring and understanding. I'm quite new, but I must say the staff are brilliant.'

However, a person who used the service described some staff as being abrupt on occasions and another said staff were rough in how they supported them. A complaint had previously been raised with the management team which stated a staff member was, 'Not helpful, rough, had a poor attitude'. This complaint had not been sufficiently addressed and will be referenced further within this report in the Responsive domain.

We noted inconsistencies in the way staff approached and cared for people. For example, staff recorded within one person's daily record that they had supported them to have a wash and get dressed whilst on the toilet. This is not good practice or a dignified way to provide people with personal care support. We highlighted this entry to the provider for them to address this with the staff member involved. People were also not routinely given choice about their day to day life. We observed a staff member stood over and slightly behind a person whilst putting a beaker into their mouth. They did not speak to the person, explain what they were doing or ask them whether they wanted a drink. Another person was brought through into the lounge from their bedroom. They were placed in front of the television without staff asking whether they wanted to watch the television or move into a more comfortable chair. People were not always offered a choice of drink at mealtimes.

We did not observe staff acting in a manner that undermined people's dignity. Staff knocked on people's doors before entering and closing their door before providing personal care support. A person who used the service stated, "The staff treat me very well; they call me by my first name. I like that. When helping me they close the curtains and shut the door." Staff spoke about people in a respectful manner. This demonstrated to us that most staff promoted people's privacy and dignity.

We also observed warm interactions between staff and people who used the service where a rapport had been established. A staff member was trying to encourage a person to participate in an activity they thought they would enjoy. They lowered themselves so they could speak to the person at eye level and stroked their hand; the person smiled widely at them in response. We observed a staff member patiently guide somebody to stand from their chair offering them words of encouragement. Staff expressed concern for people's emotional welfare and provided reassurance. For example, a person said to a staff member, "I love you" and they replied, "I love you too". They then brought the person a blanket to get warm and a teddy bear to hug. The person smiled and talked to the teddy describing it as 'beautiful'.

Some of the staff spoke about their job with enthusiasm and were aware of the impact they could have on people's lives. A staff member told us, "I wouldn't ever rush people. Instead of seeing things as a task, I see them as a person. My position is to treat everyone as an individual. I care passionately about people having good care."

People's relatives and friends told us they felt welcome to visit and were offered drinks and invited to stay for dinner.

Communication care plans were in place and described the actions for staff to take to enable people's communication. For example, one person's care plan stated, 'Staff need to talk slowly and face to face, giving them time to comprehend and answer.' The staff we spoke with were familiar with people's communication needs.

We noted an accessible cabinet which contained lots of confidential documents relating to people who had previously used the service. We highlighted this to the provider and the documents were moved before the second day of our inspection. All other documentation was safely stored away to ensure people's confidentiality was maintained.

Advocacy support agencies are independent organisations who provide people with support to make decisions and express their views. Some people had previously had the input of advocates and the management team understood in what circumstances somebody may require advocacy support.

Requires Improvement

Is the service responsive?

Our findings

Care plans described the type of support people required with different elements of their life including their personal care, nutritional needs and keeping safe. Care plans were detailed but the information contained within them was not consistently up to date. For example, two of the people we reviewed had greatly improved since moving to Crystal Court but their care plans did not reflect their current needs or developing abilities. For another person, their care plan directed staff to complete food and fluid charts due to concerns about their weight and whether they were eating enough. However, the GP reviewed this person and it was agreed that monitoring was no longer required. This meant care plans did not fully reflect people's current needs. As the staff were familiar with people's needs, this reduced the risk of people receiving support that was not appropriate.

Reviews of people's care plans and risk assessments were completed. However, these did not demonstrate the inclusion of the person or their relative to ensure they were happy with the care being provided and whether any changes were needed. Many of the people we spoke with were unsure what information was contained within their care plans. A person told us, "The care staff deal with all my care." This meant people were not consistently enabled to participate in decision making around their care.

Each person had a 'Life Map' document in place which asked questions about what was important to the person, places that were special to them and their interests. These documents were not always completed and there was limited information about people's current and previous interests to enable staff to tailor activities towards their needs and preferences.

A failure to maintain accurate, complete and contemporaneous records is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider employed two activities worker on a part-time basis however one was away from work at the time of our inspection. The activities workers were not available on a weekend but told us they left quizzes, word searches and jigsaws for staff to use with people. On the first day of our inspection, a timetable of activities for the week was not in place and we were advised they were in the process of amending this. On our second day we saw a timetable of activities was in place which included entertainers, reminiscence and films.

However, we found there were limited opportunities for people to get involved in stimulating and enjoyable activities, should they wish to. People's records did not demonstrate that they were regularly supported to engage in meaningful activities. We observed some people spent long periods of time alone in their bedrooms and without stimulation. We asked people who used the service what they thought of the activities. Some people told us they didn't want to join in and were happy in their own company watching television or sitting quietly. For others, they felt there was a lack of activities. A person who used the service told us, "There's not a lot of activities. I sit in my room." Staff also told us they felt the activities available could be improved, "You never hear the residents say they have been out. Why can't they get a few of them together and go Christmas shopping. It was remembrance Sunday recently but people didn't go out, they

put something on the television." Activities were discussed within a recent resident's meeting and a person who used the service said, 'To be honest, it's like a prison. Unless you (the activities worker) are here we are left in our rooms. Sometimes all day and other times we are taken out of our rooms to have lunch and then taken straight back afterwards. I would like to be able to get out of my room more. It's not nice.'

On the second day of our inspection some activities were taking place. A staff member was leading people in some singing and people were playing with balloons upstairs. Some of the people appeared to be enjoying these activities.

We were advised that plans for activities were being explored. This included establishing closer links with the local schools and college, visits to different towns and cities and contact with the local church and spiritualist centre to ensure people had the opportunity to engage with and explore their faith.

We recommend the provider seeks advice and guidance from a reputable source in relation to providing people with person-centred care and opportunities for stimulation and activity.

At the time of our inspection, people who used the service and their relatives were not consistently aware of who was in charge, should they have wished to raise a complaint. However, they told us they felt confident to raise concerns with members of the staffing team and to escalate these should they not be addressed. The provider had a complaints policy which was available within the service. When complaints were made, the enquiries undertaken and the outcomes of these were not consistently recorded or sufficiently detailed to show how these issues had been resolved. For the complaint raised about staff member's conduct and treatment towards a person who used the service, there was no reference to whether a safeguarding referral was discussed with the person.

Nobody was in receipt of end of life care when we inspected the service. However, information was recorded within people's care plans about where they wanted to be cared for when they approached the end of their life and the people for staff to contact. We saw the staff had received this compliment for the care they had provided, 'Thank-you for the care and love you gave to [Name]. It was a comfort to all the family to know they were well cared for and when it came to the end it was peaceful and dignified."

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection, a registered manager was not in post. The position had been offered and the provider was awaiting confirmation of the person's start date. In the interim, the service was being managed by the provider's business manager with support from a deputy and regional manager, administrator and senior members of the care staff.

Significant concerns were raised about staffing levels, particularly at night, which had impacted the people who used the service. Whilst overall there were sufficient staff, the provider needed to develop and improve the deployment of staff to ensure people's needs were met in a timely manner. Concerns about staffing levels had been repeatedly highlighted to the provider in a variety of different forums, including residents and staff meetings and questionnaires. The provider had not taken actions to address these concerns or used this feedback to improve the quality and person-centred focus of the service.

We looked at the procedures in place for quality assurance and governance. These enable registered managers and providers to monitor the quality and safety of the service and to drive improvement. Audits were completed of care plans, staff files and the health and safety of the environment. Whilst audits were generally completed on a regular basis the most recent had been delayed as the registered manager had left and there were changes in the provider management structure. Whilst the completed checks had identified and addressed some issues, it had not consistently highlighted the issues we raised during our inspection. When the audits had raised points for improvement, timescales were not consistently agreed and work remained outstanding. The system of checks was not therefore sufficiently robust to ensure the overall safety and quality of the service.

Medicine audits were completed but had not noted the issues we found with medicine documentation and storage during our inspection.

We observed poor moving and handling practices. Whilst staff had completed training their competency to safely assist people with walking and repositioning had not been observed. The provider took immediate actions following the concerns we raised and people's competency was reassessed and training was arranged for all staff.

New staff had not received probationary reviews or had sufficient oversight with their induction programme including the training they had completed. Staff had not been provided with the opportunity to undertake training relating to the specialist needs of people who used the service. Supervisions and appraisals were in the process of being completed however some staff had not received the amount of supervisions specified within the provider's supervision policy.

Incidences of poor staff practice and had not always been adequately addressed. Investigations in relation to complaints and their outcome were not robustly recorded.

During our inspection we found a range of documentation that had not been completed or updated which

included mental capacity assessments, risk assessments and care plans.

Information relating to people's hobbies and interests was not always available and records did not demonstrate people were supported to engage in meaningful activity. We observed people spent long periods of time within their room with limited interaction from staff or opportunities for stimulation.

There was a breach of regulation in relation to staffing. We also made recommendations relating to best practice in the use of medicines, ensuring compliance with the MCA and the need to develop person-centred care. This showed us systems and processes were not established and operated effectively to ensure the quality and safety of the service. We concluded the above evidence demonstrated a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback about whether the service was well-run. A relative told us, "I think it is well run. One or two people recommended the service to us." However, other people felt the management of the service had deteriorated since the previous registered manager had left. People who used the service and their relatives were unsure of what the interim arrangements were whilst a new manager was being recruited. A relative told us, "The interim arrangements with the management, we don't know about. This could have been handled with better communication." A staff member echoed this view when they stated, "There's been a lot of upheaval and change and they (the provider) haven't guided us."

There was a variety of meetings, which included full staff and head of department meetings. Records showed that these meetings were an opportunity to seek staff feedback, to share information from recent incidents and checks of the service and to discuss the changing needs of the people who used the service.

Statutory notifications had been sent to the Commission appropriately and the provider understood in what circumstances these were required.

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 17 HSCA RA Regulations 2014 Good governance Systems and processes had not been established and operated effectively to assess, monitor and improve the quality of the services provided. Complete and contemporaneous records were not always in place. Regulation 17(1)(2)(a)(c).

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 Competent and skilled staff had not been effectively deployed to meet people's needs. Regulation 18(1).