Bupa Care Homes (HH Hull) Limited

Berkeley House

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

The inspection took place on 28 and 29 September 2017 and was unannounced. Berkeley House is registered to provide care and accommodation for a maximum of 94 people. This number includes 84 older people who may be living with dementia and 10 people who have a learning disability. Accommodation is provided separately for people who have a learning disability in small bungalows adjacent to the main home.

The main building provides accommodation over three floors accessible by lift. The homes units are; King George, Victoria and Queens, which are all residential and situated on the ground floor, first floor and second floor respectively. Facilities in the home include six lounges, five dining rooms, a conservatory, garden and a hairdressing salon. The Berkeley Square bungalows cater for up to 10 people with learning disabilities and are called Aldridge, Carlton and Trinity.

The service did not have a registered manager. 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. A manager was appointed in May 2017 and has yet to apply to register with us. We have referred to this person as the 'manager' throughout our report.

The Integrated Commissioning and Contracts monitoring team completed a Quality Assessment Framework visit in July 2017 this had identified some areas for improvement and had led to a suspension of all admissions to the service being imposed. The provider has provided an action plan describing the action they are taking to address these issues.

The provider did not have effective systems to ensure risks to people were effectively assessed, monitored and reviewed. Improvements were needed to ensure the manager and providers checks were consistently effective in identifying shortfalls and to drive improvements.

The provider did not always act in accordance with their registration; they did not always notify us of important events that occurred at the service.

There were times when the application of the Mental Capacity Act 2005, used to protect people when they lacked capacity, was inconsistent. Not everyone's capacity had been recorded. Best interests meetings held had not always included professionals in the decision making process. The manager had taken action and submitted applications to the local authority when people's liberty had been deprived; some of the applications had been authorised but several people were awaiting assessment by the local authority.

Further improvements were needed to ensure that staff received appropriate on going or periodic supervision in their role to make sure their competence was maintained. We saw that although a supervision plan was in place, few of the staff team had received any supervision.

Improvements were needed to make sure all records maintained for people were accurate and completed to show care instructions had been followed so that people received the care and support they required in line with their individual needs.

There were sufficient, suitably recruited staff to meet people's needs. People were provided with a varied and balanced diet and accessed the support of other health professionals, when required.

Staff had caring relationships with people, promoted people's privacy and dignity and encouraged them to maintain their independence. People were encouraged to keep in contact with their family and friends and visitors were able to visit without restriction.

People and their relatives felt able to raise concerns and complaints. People's views were sought in the planning of the service, but changes made were not always monitored to ensure they were effective. Staff felt supported by the manager and the provider.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to consent, safe care and treatment and governance. You can see what action we have told 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.

Systems in place for the management and administration of medicines were not robust, which meant people were at risk of not receiving their medicines appropriately.

Staff were recruited safely but how staff were deployed, especially at mealtimes, meant some people were left unattended.

Staff knew how to protect people from the risk of harm or abuse and how to report concerns. Not all staff had received regular safeguarding training updates.

Is the service effective?

Requires Improvement

The service was not consistently effective.

There had been an inconsistent application of mental capacity legislation and deprivation of liberty safeguards, which meant best practice guidelines, had not always been followed when people lacked capacity to make their own decisions.

Staff had access to training, but this had not been planned in a way that ensured training updates did not lapse. Supervision plans were in place, but the majority of staff did not receive on-going support and supervision to ensure their competency was maintained.

People liked the meals provided to them and menus indicated choices and alternatives. Improvements required in staff interventions at meal times to ensure people received timely support and assistance to eat their meals.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were observed as having a kind and caring approach.

People and relatives provided positive feedback about staff and

the care and support they received.

Discussions regarding people's end of life wishes had not routinely taken place.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The provider needed to improve activities to ensure that people who were cared for in bed had the opportunity to engage in activities that promoted their well-being.

People who used the service and their relatives felt able to raise concerns and complaints and there was a procedure in place to ensure they were responded to.

People's care plans and risk assessments lacked important information to guide staff in how to care for people in the way they preferred.

The delivery of care had at times not met people's individual needs.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider did not always fully notify us of important events that occurred in the service, as required by their registration with us. The provider's systems and processes did not always ensure that risks to people were managed effectively.

Improvements were needed to ensure the provider's quality assurance systems were consistently effective in identifying shortfalls and bringing about the necessary improvements.

The manager was caring to people who used the service, supportive of staff and keen to improve the quality of the service.

Berkeley House

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.

The inspection took place on 28 and 29 September 2017 and was unannounced. On the first day of the inspection the team consisted of; two adult social care inspectors. Two specialist advisors in governance and the Mental Capacity Act 2005 and an expert by experience whose areas' of expertise was dementia care and older people also supported this inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day of the inspection the inspection team consisted of one adult social care inspector.

Before the inspection we reviewed all the information provided by the provider and data we had received via statutory notifications since the last inspection. We contacted the local authority safeguarding and contracts and commissioning team, about their views of the service.

During the inspection, we observed how staff interacted with people who used the service throughout the day and at mealtimes. We spoke with the regional director, the manager, the residents experience manager, the area trainer, three unit managers, a senior carer, nine care staff, a domestic, the maintenance person, the cook and an activity coordinator. We also spoke with eight people who used the service, four visitors and three visiting healthcare professionals.

We looked at 16 care files for people who used the service and other important documentation which included medication administration records (MARs) and daily notes of care provided to them. We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interests meetings were held in order to make important decisions on their behalf.

During the inspection we observed how staff interacted with people who used the service throughout both days and at mealtimes. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of

observing care to help us understand the experience of people who could not talk with us.

We looked at a selection of documentation relating to the management and running of the service. These included training records, the staff rota, menus, minutes of meetings with staff and relatives, quality assurance audits, the recruitment records for eleven staff, complaints management and maintenance of equipment records. We also completed a tour of the environment.

Requires Improvement

Is the service safe?

Our findings

During our inspection we found some concerns with the management of medicines. The provider had not ensured that all staff administering medicines had the information they needed to administer the medicine as prescribed. For example where people were prescribed medicine to manage risks associated with their behaviour, staff did not have clear guidance on when this should be used. There was no detailed information as to how long the person should be agitated for, or at what intervals further medicines should be administered. The care plan offered no further guidance for staff on distraction techniques to use before administering the medicine. This showed us there were no clear systems in place to ensure that people's behaviour would not be controlled excessively by medicines.

When changes were made to people's prescribed medicines, we saw that these changes were not always updated within their care records or on their MARs (medication administration records) to show their medicine had been administered as prescribed. For example, one person who had been discharged from hospital with a change in their prescribed medicine regime had a MARs in place, but there were no signatures on the MAR to show the new medicine had been administered. Similarly we found a number of MARs with gaps and one where one person's medicine had not been obtained by the service or made available to them for a period of three days following their GP prescribing this for them. This could place people at risk of not receiving their medicines as prescribed.

A record of the 'Walk Round and Take 10' document completed for the 25 September 2017 recorded that medicine orders were eight days overdue. The providers medication policy clearly identifies that medicine orders must be sent to the GP by day eight of the 28 day cycle. This practice did not assure us that people were receiving their medicines as prescribed.

Not ensuring people received their medicines as prescribed was a breach of regulation 12 (2) (g) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the end of this report.

When we asked people if they received their medicines on time they told us, "Same sort of time each day, they limit pain relief as too much is not good for me." A relative commented, "On time, she will accept tablets from me, staff struggle to get her to take them, but no issue."

When we spoke to a visiting health care professional they told us they had recently completed medication reviews for people who used the service and during this, they had highlighted a training need with the manager for staff, on the use of Methotrexate medication.

We observed medicines being administered and saw staff responsible for this spent time with people and checked to make sure they had taken their medicine before leaving them.

When we spoke with people who used the service and their relatives they told us staff were busy, but most of the time there were enough staff available to respond to their call bells in a timely way with only occasional

delays of five to ten minutes. They told us there had been a recent staff recruitment drive and as a result of this staffing levels had improved and staff had time to sit and chat with people.

During discussions with the manager, regional director and staff told us that staffing levels had been increased and a recent recruitment drive had been successful in securing additional staff which would increase staffing levels further. Staff commented, "We have been saying staffing has been an issue for some time. I spoke with someone from BUPA and it is getting better. Things need to settle down." We saw that staffing levels were based on people's dependency levels and were kept under review. This showed us the provider had systems in place to ensure there were sufficient staffing levels provided to meet people's needs

Staff told us they had received safeguarding training, when we checked the training records we found 31 staff members had been identified as being overdue for an update of this training. In discussions with staff they could describe the different types of abuse and the action they would take should they have any concerns. The manager was aware of safeguarding referral procedures and told us they would discuss concerns with the local safeguarding team as required. However, we were aware that the provider had not notified us of a safeguarding concern that had been referred to the local authority safeguarding team by another professional. We saw that the provider had received this information in the form of a complaint and they had investigated and upheld the complaint but they could not explain to us how they had overlooked notifying us, following their findings. This would have enabled us to check if appropriate action had been taken. We have referred to this in the well led section of this report.

We found staff were recruited safely and full employment checks were completed prior to new staff starting work at the service. These included an application form to look at gaps in employment, obtaining references and proof of identity, attending for an interview and completing a disclosure and barring service (DBS) check. The DBS involved a police check to identify any cautions or convictions. These measures helped to ensure only suitable people worked with adults at risk of abuse.

When we spoke to people who used the service and their relatives, we asked if they felt safe living at the service, they told us, "Just do, yes." A relative commented," Safe, they check on him regularly and have a sensor mat."

We found risks to people's safety and well-being were not always effectively assessed and managed. We saw that when people presented with behaviour that may challenge themselves and others, risk assessments were not always completed. We saw a record dated 27 September 2017 for one person who had been going into other people's rooms and when staff had intervened to stop them they had physically lashed out at staff. When we spoke with the manager about this incident they told us that staff had not shared details of the incident with them. When we looked at the person's care plan it detailed that staff should calm the person and listen to what was making them anxious, but gave no information about how staff could achieve this.

The environment was safe for people to live in and staff to work in. Staff had access to personal, protective equipment such as gloves aprons and hand sanitiser. Rooms such as sluices, and cupboards containing cleaning products and equipment were secured and made inaccessible to people who used the service . Equipment used, such as hoists, specialised baths and electrical appliances were serviced and maintenance personnel told us any repairs were completed quickly. People had individual plans for use in emergency evacuation of the building and there was a contingency plan for situations such as a flood and a failure of utilities in place.

Checks were in place for hot water outlets, nurse call systems the fire alarm system, emergency lighting, fire

doors and extinguishers. A system was in place to flush through unused water outlets in unoccupied bedrooms as part of a risk assessment to plan to prevent legionnaires disease.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the 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 interest and as least restrictive as possible. We checked whether the service was working within the principles of the MCA and whether any conditions or authorisations to deprive a person of their liberty were being met

We found the application of MCA and the Deprivation of Liberty Safeguards(DoLS) was inconsistent. For example, the standard of the completion of forms indicated the assessors did not fully understand the process or how to fully explore different communication methods, whether and how the person could process the information and make a decision. We were unable to find any capacity assessments records to support the use of best interest decisions. Each best interest decision had a statement that a capacity assessment had been done, but we were unable to obtain records of these.

Only two of the best interest decisions we saw had an external party involved and one of these decisions was refused. Most assessments included only the person, a relative and a staff member and for most of the decisions there was little objective reasoning recorded both for and against the decision being made.

A best interest meeting held for one service user in relation to the administration of covert medicines did not demonstrate any alternatives had been considered, for example providing the medicine in a liquid form. The staff had also not discussed the possibility of any implications of the medicine being taken in this way with the dispensing pharmacist as part of the decision making process.

In one person's record it was clear that an authorisation of a DoLS was seen as an indication that the person lacked capacity and needed to be supported in their decision making. In September 2017 there was a clear statement in the record that the DoLS related only to where the person resided. However, records made by staff stated that as the person was subject to a DoLS and they needed to be supported in making decisions.

A best interests record for another person detailed that staff should implement a strict diet and ensure the diet was adhered to even when the person demonstrated distressed behaviour. No capacity assessments had been carried out, there had not been any external professional input or an advocate used to support this decision.

Similarly although a number of people were supported by deputies appointed by the Court of Protection or by people who had Lasting Powers of Attorney, records did not contain copies of the registered Lasting Powers of Attorney or the details covered by the powers. This evidenced that the scope of a DoLS authorisation and MCA was not fully understood by staff and meant we could not be assured that people's rights were consistently upheld.

Not working within the principles of the MCA and DoLS is a breach of Regulation 11 (Need for consent) of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the end of this report.

People's nutritional needs were assessed and a screening tool was used to identify any concerns. Staff monitored people's weight and referrals were made to health professionals when required. Catering staff received information about people's nutritional needs and provided a varied range of foods and drinks. Choices were available at all mealtimes. On the first day of our inspection while we were speaking to a person who used the service we saw a handwritten note on their bedside table stating they could only have 'thickened drinks', shortly afterwards a staff member left an un-thickened jug of juice in their room. When we queried this with the senior staff member on duty they told us it shouldn't have been provided and immediately removed it.

We observed the lunchtime experience for people and saw that in the unit supporting people with dementia there were not enough staff available to support people to have their meals. When we spoke with the manager about the staffing levels over the lunchtime period they told us they had requested two meal sittings be provided so that people wouldn't have to sit in the dining room and wait for staff to support them. They told us they would arrange for the resident's experiences manager to complete a mealtime experience observation to assess what could be done to improve people's mealtime experience.

Staff were seen to be attentive and chatted with people asking them if they were enjoying their food, if they would like some more or if they were ready for their pudding. People were seen to enjoy the interaction with staff and engaged in conversation or smiled and nodded as they listened to staff.

People who used the service told us they could choose to sit where they wanted to have their meals and that choices were offered every day.

We were unable to determine whether people who required support with fluid intake were being offered adequate hydration. Records inspected showed inconsistencies in recording. This included when people were required to have their drinks thickened, details of drinks provided and records of fluids being thickened did not match up. For example one person's records indicated they had been given eight drinks totalling 1010 mls of fluids, their thickener protocol and recording form indicated only four of these drinks had been thickened to the correct consistency for them to take. We have referred to this in the well led section of the report.

When we asked people who used the service and their relatives about staff they told us, "Happy, chatty and very attentive and seem to be a happy crew." and "With mum they treat her with dignity."

We looked at records for supervision and we found that although this had been planned for, only twelve members [approximately 10%] of the staff of the staff team had received any supervision. Staff confirmed with us they had not received supervision or appraisal. When we spoke with staff, they told us the recent focus had been ensuring that staff training was brought up to date.

Further sessions had also been planned for the 6 and 9 October 2017 for staff competency checks to be completed. Not ensuring all staff receive appropriate on going or periodic supervision in their role to make sure their competence was maintained is a breach. The manager and regional director and area trainer were able to provide us with details of training that was planned to take place to address the staff training that had lapsed.

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

Regulations 2014. The action we have asked the provider to take can be found at the end of this report.

Bedrooms were seen to be personalised with photographs and personal belongings.

Requires Improvement

Is the service caring?

Our findings

We observed positive interactions between staff and people using the service. When we observed one person become distressed we saw staff responded immediately, offering them their hand and reassurance. Another person who was sat alone was approached by staff and asked if they would like some company, the person smiled in response and asked them if they would like to sit down. We observed throughout the day people being consulted on an individual basis about what they would like to have for their lunch or activities they may like to attend.

When we asked people who used the service and their relatives about staff they told us staff were respectful and kind. Comments included, "Generally very good, professional. I can talk to them." Other people told us, "With mum they treat her with dignity" and "All alright, if they can help they will." Another person told us, "A lot of times they are demoralised due to staff changes; not told why they are moved."

A visiting healthcare professional told us that they felt recent staff changes where staff had been moved to different units within the building had contributed to a lack of continuity of care for people. They gave an example of a new senior staff member being more knowledgeable about people than staff who were now allocated to work with them.

We found improvements were needed to ensure people's preferences were recorded within their care plans to ensure consistency was achieved. We found detailed information in two of the care plans we looked at that described their preference for a male of female carer and details such as preferring to have their light left on and two pillows and one blanket on their bed. Others lacked details of any preferences people had, or any evidence to show these discussions had taken place or been attempted.

When we spoke with the manager about this they told us that they had identified inconsistencies in care plan information. Following this they had arranged care plan training for staff and planned for the week commencing 2 October 2017. This was confirmed by the area trainer and by staff we spoke with.

We looked at 16 people's end of life care plans and found only two of the 16 had their end of life wishes and preferences or future plans recorded. The others were blank or indicated 'DNACPR in place.' (Do Not Attempt Cardio Pulmonary Resuscitation) The purpose of a DNACPR decision is to provide immediate guidance to those present [mostly healthcare professionals] on the best action to take [or not take] should the person suffer cardiac arrest or die suddenly. We recommend the provider reviews this to ensure appropriate discussions have taken place with people and their relatives about their wishes and this information should be recorded in people's care plans.

During our inspection of each of the units we had no concerns about staff practices. We found staff were attentive to people's needs, they provided explanations before carrying out tasks and were patient and kind. Staff were observed knocking on bedroom doors and asking permission before entering.

We found people's personal information and their care files and medicine administration records were held

securely. Computers used within the service were password protected to help secure data. Staff were aware of the need to protect confidential information and we saw telephone calls and discussions with health professionals were held in an office or in people's bedrooms.

Requires Improvement

Is the service responsive?

Our findings

We found there was an inconsistency with people's care plans. We found detailed information in two of the care plans we looked at that described their preference for a male of female carer and details such as preferring to have their light left on and two pillows

Other care plans did not always have sufficient information to show that people's needs were adequately planned for to provide appropriate guidance for the staff. Risk assessments we saw did not contain the measures staff were to use to help minimise risk. For example, in one person's care plan staff were instructed to calm [Name] down and to listen to what was making them anxious. There were no examples for staff about what type of verbal reassurances would be effective and in which circumstances this approach was to be used.

In another person's care plan a behaviour assessment had been completed, but no evaluation of the data or recommendations were recorded. Records we reviewed for a third person had no plans at all for the management of behaviour that was challenging and had caused them, other people who used the service and staff, anxiety and distress.

We found that information in people's care plans was not always updated in line with their changing needs. For example, we saw information in one person's care records that described them to be independent with washing and dressing. Their monthly evaluation records detailed, 'requires supervision with personal care and to change clothing.' Followed by a further record stated, 'continues to have assistance from one carer with washing, dressing and personal care.' The changes in the person's needs were not updated within their care and support plan.

We found in another person's daily records, that they were discharged from hospital with a change in their dietary needs. When we looked at their care records, we found this information had not been updated. This omission placed the person at risk of not having their dietary needs met.

Other people's care plans contained positional charts, which were not fully completed. In some we found details of the frequency of positional changes was not recorded, while in others the records did not correspond to the timescales people should have their position changed. We have referred to this in the well-led section of the report.

A visiting healthcare professional we spoke with told us the nurse team overall had shared concerns that had led to two safeguarding referrals being made to the local authority safeguarding team in relation to a lack of documentation. They explained that positional charts had not been completed and indicated people had been left in the same position for lengths of time which were not in keeping with the nurse's instructions. They voiced their concerns with us about the potential risks to wellbeing for people who were unable to change their position independently.

They told us they had recently met with the manager and the regional director to raise their concerns and

impress the importance of these being fully completed.

The nursing team acknowledged that staffing levels had improved, but the coordination of care needed to be improved further. They gave an example of how if a staff member was allocated to them while they were seeing their patients; this would improve continuity and communication.

They gave an example of a recent situation where communication could have been better, where the nursing team had been requested to assess pressure damage for a person who used the service.

During their visit they found the person with a dressing at a different site and when they raised with staff the reason for this, they were told the emergency care practitioners had applied a dressing to a skin tear. A review of the person's records detailed that the dressing be checked by the district nurse five days later. The record showed that the dressing was left unchecked for 17 days, despite nurses visiting the service on a daily basis.

We saw there was a range of activities available for people to participate in if they chose to. A programme of all activities available was on display throughout the service. When we spoke with the activity coordinator, they told us a varied programme was available in line with people's preferences and any sessions attended were detailed in people's care records.

When we spoke with people who used the service about activities they told us, "It is very difficult she is almost blind, a couple of days ago they took Mum around the garden." Another person commented, "None, as he is too poorly." During our inspection, we observed a music and keep fit session on the Queens unit. As soon as the music started, we saw people coming out of their rooms to attend the session. When staff acknowledged one person in passing, they replied to the staff member that they could not stop to chat, as they did not want to miss the activity.

We were unable to establish what activities were available for people with more complex needs, as records in people's care files were not fully completed. When we spoke with the manager and regional director, they told us the activity coordinator maintained their own record of activities people had participated in, as well as the records maintained by care staff. This meant that staff did not have the current information about activities these people had engaged in. The manager offered us assurances that this would be immediately addressed.

The provider had a complaints policy and procedure on display. This detailed who to refer complaints to and timescales for acknowledgement and completion. We saw that complaints received by the service, were recorded and responded to, in line with the provider's complaints policy.

One complaint received by the service in June 2017 alleging poor care of their relative, had been upheld by the service. However, the details of this were not been notified to CQC or to the local authority safeguarding team. We have reported on this in the well-led section of this report.

Requires Improvement

Is the service well-led?

Our findings

The manager of the service had been in post since May 2017, which meant there had been three different managers at the service within the last twelve months. When we spoke with people who used the service and visiting health care professionals about the manager we received a mixed response with some people commenting that the service was now better than it was previously and the new manager was more organised. Others were less enthusiastic after experiencing three managers in a short period of time they told us, "I'm waiting to see if changes they say will happen, do, but she is saying all the right things."

When we spoke with the manager, they told us they were committed to the service and wanted to develop the service so people were safe and happy. They said they wanted relatives and visitors to visit because they wanted to, not just because they worried or wanted to check up on their relative. They also wanted to create an environment where staff wanted to come to work and were proud of the care provided.

The manager told us that following their appointment, they had quickly identified issues within the service and requested support to address these. A regional manager was assigned to support them, but the manager felt further resources were needed to address the identified issues in a timely manner.

The Integrated Commissioning and Contracts monitoring team had completed a Quality Assessment Framework visit in July 2017. This had identified some areas for improvement and had led to a suspension of all admissions to the service being imposed. In August 2017, a regional director from the service recovery team was provided to support the manager in addressing the identified issues and to improve the service.

The manager and regional director developed an action plan and identified timescales for the completion of this work. Although we were able to see there had been some progress made for example, staffing levels increased, a senior management team developed and a head of care appointed to support the manager with the clinical side of the service; there was still further work that needed to be completed.

We found audits and checks were completed, but these had not always been effective in identifying all of the shortfalls we found during our inspection. For example; in relation to risk management, medicines management and not working within the principles of the Mental Capacity Act. Although some shortfalls had been identified, these had not been acted on in a timely manner and some areas of concern were identified but we found they had occurred again. For example; people's postural change and fluid intake records were found to be incomplete, despite clear instructions being given by the manager requesting senior staff check these were being completed fully on a daily basis.

We found staff also needed regular supervision in their roles to make sure their competence was maintained. Although training had been planned, there were still some staff whose training had lapsed.

Not ensuring there was an effective system of governance and the quality monitoring in place was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the end of this report.

During our inspection we identified a number of concerns that required improvement. This included; ensuring care plans were person centred, assessments of risk, positive behaviour support plans, accurate completion of fluid intake and postural change records and the application of a consistent approach in accordance with the Mental Capacity Act 2005.

We saw that the number of accidents had been collated but there was no effective analysis and action plan produced to help to minimise accidents and incidents from occurring again. We saw that the number of accidents had been collated but there was no effective analysis and action plan produced to help to minimise accidents and incidents.

Not maintaining accurate, complete and contemporaneous records is a breach of regulation 17 (2) (c) (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the end of this report.

A complaint received by the service in June 2017 in relation to potential neglect, was upheld following an investigation, this had not been shared with the local authority safeguarding team or notified to CQC.

Not notifying us of incidents, which affected the safety, and welfare of people who used the service is a breach of Regulation 18 (Notification of other incidents) (Registration) Regulations 2009. On this occasion, we have written to the provider reminding them of their responsibility regarding notifications to CQC.

We saw staff meetings had taken place where people were able to express their views about the service, but some staff we spoke with felt these tended to be a list of changes and issues and could have a negative effect on staff morale. Staff told us that although there had been positive changes for example, increased staffing, there were other issues that needed to be addressed further.

One issue consistently raised was with the provider's recording paperwork which they felt was lengthy and repetitive. Comments included, "I feel there is more and more paperwork and less time for caring. We prioritise care so people don't lose out but we get told off if the paperwork is not up to date [More of a balance would be better]". Others commented, " We do the care first, when we have so much to do you can miss the odd bit of paperwork e.g. food logs if they are not completed straight after meals, it can be an issue" and "We have people who have fluid and food charts who have their meals in the dining room. Their charts are in their rooms, this makes things more difficult and we can miss recording information."

Relatives confirmed they attended meetings and completed a survey about the service.

Staff told us they were given an employee handbook which provided information about roles and expectations. This helped staff to know what was expected of them and also what they could expect from their employer. It also provided information about the values of the organisation, relevant policies and procedures and ways of working.

We have asked the manager and regional manager to provide us with an action plan of how they will work towards achieving compliance.

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	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not consistently acted in accordance with the Mental Capacity Act 2005 in relation to when service users were unable to give consent because they lacked capacity. Capacity assessments were not in place to support staff were acting lawfully in relation to aspects of people's care and treatment. Regulation 11(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured medicines were administered accurately and in accordance with the prescriber's instructions. When people placed themselves or others at risk of harm, there was not a planned approach to support them or others. Regulation 12(2)(a)(b)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not always ensured there was an effective system of governance and the quality monitoring in place. Effective systems or processes to assess, monitor and improve the quality and safety of

	the services provided and mitigate risk had not been operated fully. There were shortfalls in recording systems.The registered provider had not consistently ensured accurate, complete and contemporaneous records were maintained. Regulation 17 (1) (2) (a)(b)(c)(e)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staff received training, supervision and appraisal as necessary to enable them to carry out the duties they are employed to perform. Regulation 18(2)(a)