Durham Care Line Limited

De Bruce Court

Inspection report

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14 August 2019
15 August 2019

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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?	**Inadequate**

Summary of findings

Overall summary

About the service
De Bruce Court is a residential care home providing personal and nursing care to 23 people at the time of the inspection. Care is provided to younger adults and older people, some of whom have dementia, physical disabilities or mental health needs. The service can support up to 46 people.

People's experience of using this service and what we found
The service was not well led. The provider failed to have enough oversight of the home and on-going breaches of regulations were identified. The areas for improvement we identified at our last comprehensive inspection had not been addressed which affected the safety and experiences of people living at the home. Systems to monitor the quality and safety of the service and support continuous improvement were not effective. People's care records were not always complete or accurate. Agency staff records were not complete and appropriate checks on nursing staff were not in place.

Most staff worked hard to meet people's needs, however staff deployment required improvement and we have made a recommendation about this. Staff had little time to meet people's emotional needs as care was often focused on completing tasks quickly. Care staff were expected to carry out additional tasks which resulted in less time to spend on care and support. People said delays in care sometimes affected their dignity.

People did not receive consistently safe care and medicines were not always managed safely. Staff recruitment procedures were not always thorough and identity checks had not been carried out on agency staff.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Some people had not had their ability to consent to the care they received assessed. Decisions made in people's best interests had not always been recorded appropriately.

People had mixed views about whether they were treated with dignity and respect and whether they were involved in decisions about their care. Whilst most staff had completed training in quality and diversity we did not always see this reflected in practice. Some staff had a caring approach, but other were task-focused.

There was a lack of activities to keep people engaged and people told us they felt under stimulated. People and relatives knew how to complain, but they said complaints had not always been handled appropriately or to their satisfaction. We have made a recommendation about complaints.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)

The last rating for this service was requires improvement (published 1 November 2018) and there were two breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

We carried out a focused inspection on 13 March 2019 to see if improvements had been made and whether regulations were met. We found improvements had been made so there was no longer a breach of Regulation 18. However, there was an ongoing breach of Regulation 17 as the provider did not have accurate and complete records for each service user.

The provider completed an action plan after our focused inspection in March 2019 to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was in breach of five regulations. We have made recommendations about staff deployment, activities and complaints.

Why we inspected
The inspection was prompted in part due to concerns we received about staffing levels, staff deployment, medicines and staff turnover. A decision was made for us to inspect and examine those risks.

We began our inspection by carrying out a night visit to check staffing levels on 13 August 2019. We returned on 14 and 15 August 2019 to undertake a focused inspection to review the key questions of safe and well-led. Whilst doing so we found areas of concern in the other key questions, so we reviewed all the key questions, which meant we carried out a comprehensive inspection of this service.

The overall rating for the service remains requires improvement. This is based on the findings at this inspection.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
At this inspection we identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to the need for consent, safe care and treatment, good governance, staff training and fit and proper persons employed. Please see the action we have told the provider to take at the end of this report.

We issued a warning notice relating to the breach of regulation 17 (good governance).

Since the last inspection we recognised that the provider had failed to display their CQC rating on their website. This was a breach of regulation and we issued a fixed penalty notice. The provider accepted a fixed penalty and paid this in full.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

De Bruce Court

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by three inspectors, a pharmacy specialist, a specialist advisor (nurse with expertise in older people's care and quality assurance) 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. Two inspectors visited on the evening of 13 August 2019. Two inspectors, a pharmacy specialist, a specialist advisor and an Expert by Experience visited on 14 August 2019 and two inspectors visited on 15 August 2019.

Service and service type
De Bruce Court 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.

The service did not have a manager registered with the Care Quality Commission. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority, professionals who work with the service and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and

social care services in England.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with eight people who used the service and six relatives about their experience of the care provided. We spoke with 17 members of staff including the manager, the deputy manager, the provider's representatives (the head of care delivery and the head of care outcomes), the provider's regional catering lead, the provider's therapeutic service manager, two nurses, two senior care assistants, four care assistants, the chef, the administrator and the HR administrator. We spoke with the nominated individual who is responsible for supervising the management of the service on behalf of the provider. 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 a range of records. This included three people's care records and multiple medicines records. We looked at five files in relation to staff recruitment and seven files in relation to staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at people's weight records and the staffing dependency tool.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- Medicines were not managed safely. Medicine records had not been completed correctly and medicines for two people were out of stock.
- Care plans and risk assessments were not always up to date and did not reflect people's current needs regarding medicines.
- Prescribed creams and ointments were not administered effectively. There was some guidance for staff about where or how often to apply creams, but for some people the guidance was incomplete. There were gaps in topical creams records. The provider was in the process of reintroducing paper records to address this issue.
- Guidance for staff on 'when required' medicines was not always available or person-centred. 'When required' medicines are given as the need arises, for example to relieve pain or reduce distressed behaviour. Staff did not always record the reason they had given these medicines, or the outcome for the person, to show whether the medicines had been effective.
- Where people were prescribed medicines in the form of a patch, records were incomplete and patches were not always applied to different parts of the body following the manufacturers guidance, which is necessary to prevent people experiencing side effects.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Risks were not always well managed. The loft space was not secured which put people at risk of harm. When we mentioned this to the manager and provider representatives they took immediate action to address this.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- When we started the inspection on the evening of 13 August 2019 we found all eight staff on duty had not completed training in how to use evacuation equipment. There were two people on the first-floor unit who would have needed such equipment to be evacuated safely, for example in the event of a fire. Out of 55 staff only 10 had completed training in how to use evacuation equipment. We could not be sure staff knew how to evacuate people safely in an emergency due to this training need.

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

● Following the inspection, the provider told us that all staff had been trained in how to use the evacuation chair within the home.
● Handover records were not detailed enough as they did not contain enough information to enable staff to support a person safely. They only contained people's medical diagnoses rather than an overview of people's care and support needs, and how they had been on the day in question.
● Each person had an up to date personal emergency evacuation plan (PEEP) and there were regular fire drills.
● People's care plans included risk assessments about individual care needs such as eating, drinking and walking. Control measures to minimise the risks identified were set out for staff to refer to.
● Risk assessments relating to the environment and other hazards, such as fire and food safety were carried out and reviewed regularly.
● Regular planned and preventative maintenance checks were up to date.

Systems and processes to safeguard people from the risk of abuse
● People and relatives had mixed views whether the service was safe. One person said, "I don't feel safe as staff are never there when you need them." Another person told us, "I feel safe because of all the people looking after me."
● Safeguarding incidents had mostly been recorded and acted upon appropriately. However, we did find a recent safeguarding incident which had not been recorded appropriately or passed to the local safeguarding team. We received information after the inspection this had been rectified.
● Staff had completed safeguarding training.

Staffing and recruitment
● Most people, relatives and staff felt more staff were needed. One person said, "When I buzz for staff they say they're busy with other people." Another person commented, "Staffing is always an issue, especially at night."
● We saw people's needs were mostly met in a timely manner, but on occasions it was difficult to locate a staff member.
● Staffing levels and rotas were determined by a dependency tool. However, these only reflected people's needs in terms of basic care tasks. The provider had not adopted a holistic approach which made provision for activities and meaningful interactions between staff and people when deciding on staffing levels.
● Staffing levels did not consider the geography of the building when bedrooms on the first floor were in use. When we started the inspection on the evening of 13 August 2019 we found one staff member was assigned to the first floor for the night shift. There were six people on the unit, two of whom required two staff to support them with personal care. The staff member said if they needed extra staff to help them support people they pressed the call bell in the lounge. There was no set routine for night staff based on the ground floor to check on people on the first floor or the lone staff member. When we discussed this with the management team they said they would look into the use of radios for night staff.
● Staff told us they did not always have enough time to complete electronic records in a timely manner as they had too much to do when supporting people. Records we viewed showed staff often completed records in the evening, despite people being supported throughout the day. Without accurate records we could not be sure people received the support at the time they needed.
● Staff were not given enough time to do everything required of them outside of care delivery, such as filling in documents, handovers, engaging with healthcare professionals, talking to relatives, checking cleanliness, supervisions and their own personal development. Care staff were also expected to engage people in

activities and assist with the laundry for the whole service as there was no dedicated laundry worker.

We recommend the provider reviews the tasks care staff are expected to deliver and the deployment of staff in general.

● Recruitment procedures were not always safe which placed people at risk of harm. Staff files did not contain full employment histories which meant adequate background checks had not been carried out to ensure staff were safe to work with vulnerable adults. Disclosure and Barring Service Checks had been carried out but these had not been recorded accurately.
● There were no checks on the identity of agency staff or their competence to work. Agency staff were used regularly to cover shortfalls due to recruitment issues, sickness and holiday cover. When we discussed this with the management team they said they would address this immediately.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There continued to be a high turnover of staff which meant staff did not stay long enough to form effective relationships with people who used the service. One person said, "They've gone through about six managers since the place opened. A few weeks ago about 11 care staff left." When we spoke to the manager they acknowledged that staff turnover continued to be an issue, but said they were continually recruiting.

Preventing and controlling infection
● The home was mostly clean although there was an unpleasant smell on the upstairs unit when we visited on the evening of 13 August 2019. Domestic cover was only provided from Monday to Friday.
● A relative told us, "The home is not always clean and sometimes smells. Sometimes the cleaner is taken off her job to support the care staff. There needs to be at least two cleaners on to clean the home and see to the laundry."
● During our inspection a member of care staff was carrying out cleaning duties as the domestic staff member was on holiday. This member of care staff was cleaning the toilets and bathrooms but had no cleaning schedule to refer to. When we spoke with the manager they said they had forgotten to give the staff member the cleaning schedules.
● Staff had access to protective personal equipment such as disposable gloves and aprons.
● Staff had completed training in infection prevention and control.

Learning lessons when things go wrong
● Where an issue had arisen, or an event had taken place within the home, this was shared with staff at team meetings, supervisions and any actions needed explained. However, this was not done consistently and as a result there continued to be shortfalls within the home.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff did not always have the skills to deal effectively with people's individual needs as they had not completed relevant training. Out of 55 staff one staff member had completed Parkinson's awareness training and six had completed Asperger's awareness training. People using the service had needs in these areas. 21 out of 55 staff members had not completed training in dementia awareness; there were a number of people at the service who lived with a dementia. One relative said, "Staff have no understanding of Parkinson's or dementia."
- Staff were not trained in how to support people with swallowing difficulties (known as dysphagia) which placed people at risk of harm. The provider's representative told us they had already identified this was an area for improvement and dysphagia training booklets were being given to staff during our inspection.

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

- Staff supervisions and appraisals were mostly up to date.
- New staff completed an induction to the service and were enrolled on the Care Certificate. The Care Certificate is a standardised approach to training and forms a set of minimum standards for new staff working in health and social care.

Supporting people to eat and drink enough to maintain a balanced diet

- Incomplete records meant we could not always be sure people received enough to eat and drink. The times entered on the electronic system for food and fluid intake reflected the time the staff member made the entry, not the actual time food or fluid was offered or consumed. Records did not always state what size portion of food a person was offered and how much they had eaten.
- Where people's fluid intake was monitored a daily target fluid intake was not always set for staff to refer to. Where a target was specified it was unclear what this was based on, and there was no guidance for staff to follow if a person failed to reach their daily target intake.
- One person's care plan stated they needed a high calorie and high protein diet. The information kept in the kitchen for the chef to refer to recorded this person needed a high calorie diet, but there was no mention of the need for a high protein diet. Whilst people had not come to harm as a result of these areas for improvement, the lack of accurate care records placed people at risk of harm.

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

● People were supported to eat where they chose. The meal time experience had improved since our inspection in September 2018. The larger dining room on the ground floor was now used which meant the atmosphere was now more pleasant and relaxed. Staff were courteous and attentive to people's needs, and people were supported to eat at their own pace. One person who lived on the first floor told us how much they enjoyed going downstairs for meals.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. 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 and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● The service was not working within the principles of the MCA. Mental capacity assessments had not always been carried out when required. Where people were unable to give their consent, decisions had not always been made in their best interests and documented appropriately. Some records of best interest decisions showed the involvement of the deputy manager alone, without the involvement of the person's family or other professionals involved in their care.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support; staff working with other agencies to provide consistent, effective, timely care
● People were supported to access appointments with healthcare professionals such as the GP and optician. Referrals to other health care professionals were made appropriately. Care plans reflected the advice and guidance provided by healthcare professionals, but this was not always followed by care staff. For example, one person was prescribed medicine which required their urine output to be monitored but this was not being recorded.
● Some care plans contained 'hospital passports,' but not all. Hospital passports are communication tools to inform other health services and professionals of people's individual health needs.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Assessments of each person's needs were completed before a care placement was agreed or put in place.
● Following the initial assessment, risk assessments and individual support plans were developed with the person and their representative where appropriate.

Adapting service, design, decoration to meet people's needs

● The provision of pictorial signs and visual and tactile items to support people living with dementia had improved since our inspection in September 2018.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People and relatives had mixed views whether staff were caring. One person said, "Some staff are excellent, but others haven't got a caring bone in their body. It's the residents that lose out. We seem to be near the bottom of the pecking order." However, a relative told us, "Staff are nice and approachable." Another relative said, "Sometimes I'm happy with the care [family member] receives. It depends what staff are on. Some are great but unfortunately not all are."
- Some staff were caring in their approach, but others were task-focused in their interactions with people. When people became distressed, some staff did not always know how to support people to reduce their anxiety.
- Staff didn't spend meaningful periods of time with people as they had too many other tasks to do because staff deployment was an issue.
- Whilst most staff had completed equality and diversity training, we did not see that people's human rights were always respected in practice, as described above.

Supporting people to express their views and be involved in making decisions about their care

- People had mixed views about being asked for their opinions and being involved in decisions about their care. One person said, "My opinions are heard but not listened to. There are parts of my care plan I don't agree with and I've asked to get it sorted but am still waiting." When we discussed with the manager they said they had arranged a meeting with this person to discuss this. Another person told us, "Yes my opinions are listened to."

Respecting and promoting people's privacy, dignity and independence

- People had mixed views whether their independence was promoted. One person said, "They don't really help me to be independent at all." Whilst another person told us, "They help me by letting me get washed myself."
- People had mixed views whether they were treated with respect and dignity. One person said, "Most staff just come straight in without knocking." When we discussed this with the manager they said this may have happened previously and thought it related to staff who no longer worked at the service. Another person said, "Yes staff always knock."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Activities were limited and did not meet the needs of people who used the service or protect them from social isolation. There was no dedicated activities lead and the provider expected care staff to engage people in hobbies and interests. There was a list of activities displayed in the home, however, we did not see these taking place during our visit. Care staff rarely had the time to support people with activities. People appeared to spend long periods of time in the same chairs in lounges.
- People and relatives told us more could be done with regards to activities and stimulation. A person said, "There's no atmosphere because there's nothing going on." A relative told us, "I believe [family member] is bored and lacks stimulation. There is very little going on. There should be an activities co-ordinator."
- There was a sensory room for people to use. However, we observed there was only a bubble lamp in the room and a few chairs. There was no other equipment in the room that provided visual and physical stimulation to people. The manager said other items needed to be ordered and this was still a work in progress.
- When we spoke to the manager they acknowledged that activities needed to be improved. They told us they were looking into transport so days out could be arranged.
- At our previous comprehensive inspection in September 2018 we noted that the hydrotherapy pool had never been used by people living at the service. This was still the case at this inspection. The manager told us they were waiting for a part so the pool could be used safely, but expected this to be fitted soon. We noted that no staff had been trained in how to support people to use the hydrotherapy pool safely. Therefore, it seemed it could be some time before people could use the pool safely.

We recommend the provider reviews activities provision at the service.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care plans were mostly person-centred regarding people's individual needs, but people's life histories had not always been completed. When we discussed this with the manager they said staff were working on completing everyone's life history. The provider told us, following the inspection, that not all families and people were either able and/or willing to support the service in filling these documents in. They said they had recognised this, but felt they were taking all reasonable steps to obtain this information.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are

given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● The provider was not meeting the requirements of the AIS. One person's communication care plan had not been updated to reflect their needs in this area had changed. Staff told us about this, but records did not reflect what additional support this person would need. Given the amount of new staff at the service and the amount of agency staff used this was a concern.

● Some staff did not always know how to support people with their communication needs. For example, some staff could not communicate effectively with one person who had specific needs in this area.

● The management team told us information could be produced in other formats or languages if needed.

End of life care and support

● No one was receiving end of life support when we visited.

● Most staff had completed end of life awareness training.

● People's care plans contained their wishes where they had felt able to discuss this sensitive issue.

Improving care quality in response to complaints or concerns

● People and relatives knew how to complain, but they said complaints had not always been handled appropriately or to their satisfaction. One person said, "I've raised a number of concerns, but nothing much ever happens. Managers say they're going to sort things then don't." Another person said, "It's a waste of time complaining as they don't take any notice of you." A relative told us, "I've made suggestions rather than actual complaints, but nothing ever seems to change."

● Complaints records did not always record the outcome.

We recommend the provider reviews their complaints process.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our previous inspection the provider did not have robust systems in place to effectively monitor and improve the quality of the service. This was a breach of Regulation 17. At this inspection we found insufficient improvement had been made and the provider remained in breach of Regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; continuous learning and improving care

- The home did not have a registered manager. There had been several managers since the service first registered in October 2017. None of the managers had remained in post for more than a few months. The lack of continuity had had an impact on the governance of the service. The service required consistent leadership to support ongoing improvement.
- Quality monitoring systems were not robust or effective and did not drive improvement. The result of this was people did not always receive good quality care.
- The manager and provider had failed to identify the risks we found during our inspection. This meant they had not mitigated the risks, and as a result, people were at risk of harm. For example, audits had not identified the concerns raised during this inspection such as medicines not being managed safely and the principles of the MCA not being followed.
- Care records were not always complete and accurate. For example, the risk of pressure damage had not been assessed every month and there were no records of people's skin checks. Records relating to people's eating and drinking needs were incomplete or may not have been accurate as they were recorded hours after food or drink had been offered or taken.
- Records of people's weights were not managed appropriately. Systems were not in place to monitor and oversee people's weights and that this was being audited appropriately.
- One person's weight was not recorded as staff reported they refused to be weighed. Their care records did not detail what methods staff had attempted to weigh the person.
- One person's care plan stated, "staff to document every time person refuses personal care." Between 8 and 14 August 2019 we saw only one entry on 12 August 2019 where the person had refused personal care and there were missing entries for all other days.
- Records for agency staff were incomplete. Agency staff were used on a regular basis. Out of 21 agency staff who worked in the three weeks before the inspection there were profiles for only three staff (two nurses and one care worker). One of the nurse's profile showed their PIN number had expired in May 2019, but they had worked each week. Further checks revealed this person's PIN had been renewed, but records held at the home had not been updated to reflect this. Appropriate checks had not been carried out on nurses working at the service to ensure their registration was valid and there were no restrictions on their practice.

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Most people and relatives said the atmosphere at the home was not positive. One person told us, "Staff are demoralised." A relative commented, "The atmosphere at the home is poor as staff morale is low and communication is poor."

● Staff said the turnover of staff and the lack of a permanent manager had been challenging and morale was low. When we discussed this with the manager they said they were trying to recruit and retain staff, which they hoped would improve morale.

● People and relatives gave mixed feedback about how well the service engaged and involved them. Some relatives were satisfied with the arrangements in place, however, others expressed concern.

● Most people and relatives felt the home was not well managed. One person told us, "I don't feel things have improved here at all. There seems to be a blame culture and care staff are used as scapegoats. The home is not well managed." One relative told us, "The home is not managed well. It's gone downhill since it first opened."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● There were processes in place to help ensure that if people came to harm, relevant people would be informed, in line with the duty of candour requirements.

Working in partnership with others

● There was evidence of the service making appropriate referrals to other health professionals but care records did not always reflect the advice received.

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 11 HSCA RA Regulations 2014 Need for consent The provider was not acting in accordance with the Mental Capacity Act 2005 as capacity assessments and best interest decisions were not always in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure that medicines were managed safely. Risks to the health and safety of service users had not been assessed and mitigated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to conduct appropriate checks to ensure that staff were of good character and had the qualifications, competence, skills and experience necessary.

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 The provider failed to ensure that staff received appropriate training to enable them to carry out their duties.

This section is primarily information for the provider

Enforcement actions

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

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 The provider failed to assess, monitor and improve the quality and safety of the service by failing to operate effective quality monitoring systems. They failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. They failed to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to care and treatment. They failed to maintain accurate staff records. The provider's governance systems did not identify these risks and subsequently, steps were not taken in a timely manner to mitigate or eliminate these risks.

The enforcement action we took:

Warning notice issued.