Morleigh Limited

The Brake Manor

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
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

We carried out this unannounced comprehensive inspection of The Brake Manor on 24 November 2016. At the previous comprehensive inspection on 3 November 2014 the service was meeting the requirements of regulations. Following concerns raised with the commission in March 2015 we carried out a focused inspection. The concerns related to people not having a choice as to when they got up and went to bed, a lack of access to snacks in the evening, male residents not being supported to shave and people' not receiving adequate support with other aspects of personal care. The inspection found the allegations were unfounded.

We undertook this comprehensive inspection of the service as we had received concerns in respect of the care and welfare of people using the service. The concerns raised were that staff did not know what a person's needs were when ambulance staff requested the information. Also, that where people were at risk from skin damage, staff were not supporting them as instructed in their care plan to minimise this risk.

The provider for this location is registered under the legal entity of Morleigh Limited which is responsible for a group of nursing and residential care homes.

The Brake Manor is a care home which provides accommodation for up to 26 people who require residential care. At the time of the inspection 25 people were living at the service. Some people were living with dementia. The Brake Manor is a three story house set in an elevated position in its own grounds. The service had a range of aids and adaptation in place to meet the needs of people living there.

The service is required to 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. The Brake Manor had two registered managers in post until September 2016 when one left. The current registered manager had been managing the service on a part time basis three days a week. The registered manager was not available throughout the inspection although they had been made aware of our presence in the service and did visit the service on the day. At the time of this inspection a newly recruited full time manager had been in post for eight days.

Systems and processes to ensure good governance were not being effectively operated. Records relating to managing the health and care needs for people were not always being updated or completed by staff. People's fluid intake was not being recorded as instructed in the care plan. There were gaps in records to demonstrate people had been repositioned regularly to prevent pressure sores.

Medicines were not being managed safely. There had been no audit of the medicines system since July 2016. The medicines trolley was dirty and disorganised. There was no evidence of stock rotation. Medicines were being used when the use by date had expired. There were gaps in the records of when creams had been applied and they were not consistently signed as given. Medicines were not being returned to the

pharmacist as required. Medicines requiring stricter control were not being managed safely. The level of stock of these medicines did not reconcile with the records. We found one person was not receiving their medicine as prescribed. There were regular errors in recording medicines which required stricter controls.

Records to show when people had been repositioned due to the risk of pressure damage to their skin, were not always taking place or being recorded. One person who had been identified as requiring repositioning and had no record to show this had occurred throughout the day of the inspection. This person's care records had not been updated since May 2016 and therefore staff did not have the accurate information to enable them to deliver safe and effective care. Staff were relying on daily information from the manager. Another person required regular re-positioning. The associated records were not clear. They did not record the time or frequency of change. They did not show what position the person had been in prior to the change and what position they were in when the staff had completed the change. This meant the information could not be relied upon and we were unable to establish if people were receiving the care and support required to protect them from identified risk.

Records relating to managing the health and care needs for people were not always being updated or completed by staff. People's fluid intake was not being recorded as instructed in the care plan. One person's health had been deteriorating for some time and a professional told us they had only recently been made aware of this person's needs in order to carry out a health assessment. The person had experienced a weight loss of 10kgs in the period August 2016 to October 2016. A record of the person's food and fluid had been put in place to allow staff to monitor if they were getting enough to eat and drink. Fluid records did not show the minimum daily amounts the person should be consuming. This meant staff would be unaware if the person's intake was enough to maintain their well-being. Daily fluids recorded were not totalled or reviewed. Where people were at risk of losing weight due to a poor appetite or being unable to eat independently they had their weight recorded. However, these weight records were not being reviewed regularly to ensure that any loss of weight was identified and action was taken to address the concern. This meant care and support was not being monitored effectively.

Information in care plans was not always accurate because they had not been reviewed or updated. For example a person had recently been discharged from hospital back to the service and their needs had changed. Staff told us they had been updated about the person's needs verbally by the manager. However the person's care plan was last reviewed in May 2016 and did not reflect their current needs.

The service did not have robust recruitment procedures in place. We found staff were starting work in the service before the organisation had received satisfactory Disclose and Barring Service (DBS) checks. In one instance an employee had no record of the date they started working in the service or whether a satisfactory Disclosure and Barring Service (DBS) check was in place at the time the staff member started work. These are used to help ensure staff are suitable to work in the care sector. In two other instances recruitment files showed one person had started working at the service ten days before a completed DBS check had been received and another twenty-one days before a satisfactory DBS check had been received. The failure to complete necessary checks before allowing staff to provide care exposed people to unnecessary risk.

The environment was not being suitably maintained and there was a general air of neglect. There was evidence of some water damage to the ceiling of a bedroom on the third floor. This room also had the top drawer missing from a chest of drawers. A room on the first floor had been a bathroom. The bath had been removed although the toilet was still operational in this room. There was no floor covering for this room. Two hoists were also being stored in this room and there was a sliding door with no lock. The dignity of people using this toilet was therefore not maintained.

There was a lack of signage which would support people to move around the service independently and recognise bathroom, lounge and dining areas as well as their own rooms. This did not support the needs of people who were living with dementia, and needed prompts to help them to recognise their surroundings.

Systems for recording daily records were not robust. This was because staff removed all care plans from the office and completed the daily logs in the lounge area. However, there were occasions when staff needed to respond to call bells etc. This meant staff sometimes had limited time to complete the daily logs. In some instances staff told us they verbally passed on information to their colleagues about an event and relied on the staff member to record this.

Staff were not always being regularly supported in their role. Staff told us that, due to recent changes in managers, supervision had lapsed. Two staff files did not have any supervision records in place. Staff files were loose leaf resulting in information being difficult to find. There was a supervision matrix in place. It showed the previous manager and four of the care staff had not received supervision at all during 2016. This meant not all staff were receiving the level of support they needed to help them carry out their role and develop their learning.

Staff were caring but were not always available to people in lounge areas for any length of time to provide meaningful support. For example, two people without mobility in reclining lounge chairs spent most of the morning sleeping. They remained in the chairs when being supported with their lunch. There was little interaction seen between them and the staff members on duty. Staff were respectful and sensitive when speaking with them but there were periods of time when they were on their own without any environmental stimulation other than music playing or television. Neither seemed particularly interested in these pastimes.

People had mixed views about meals provided by the service. Some people told us they liked the food and others said it could be improved. In general we found that the quality of food was adequate though not of a high quality. Comments included, "It's not been as good as usual today" and "I have changed my mind and had the alternative." Other people told us they were not happy with the food in general. Comments included, "It's not really good even with a choice" and "Bland that's all I can say." Staff commented that the quality of the ingredients were not as good as they had been. They told us, "The tea bags and coffee are really poor quality. In general it's all about cutbacks."

There was a lack of meaningful activities for people living in the service. The manager told us activities were limited and the service relied on staff to provide entertainment. During the day there was no evidence of staff engaging in any activities and people were sat in the lounge with either music on or the TV. Staff told us they were busier now because the needs of people living at the service had increased and this meant more time was spent supporting people with their health needs with little time to meet people's social needs.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept

under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Medicines were not being managed safely. Records were not accurate and were not being signed.

The service was not ensuring recruitments checks were in place before staff began working with vulnerable people.

Staffing levels had recently been increased to respond to the level of need for people living at the service. However, due to the levels of dependency staff were not always available to respond to people's needs.

Is the service effective?

Requires Improvement

The service was not always effective. People were not always satisfied with the quality and choice of meals.

Maintenance of the service was not always taking place as necessary.

Staff had access to training in order for them to develop skills in their role. However, lack of supervision meant there was no system in place to assess staff competencies.

Is the service caring?

Requires Improvement

The service was not always caring. Staff were not always available to people as they were busy supporting people with higher needs in other areas of the service.

Staff understood the need to protect people's privacy and dignity.

Some people who used the service and some relatives were positive about the care they received.

Is the service responsive?

Requires Improvement

The service was not always responsive. There were gaps in some care records which meant staff did not always have the information to respond to people's needs.

Care plans did not always provide staff with clear information about how to respond to a person's needs.

Care plans were not always updated which meant information was not always accurate, which affected how staff responded to people's needs.

The range of activities available to people was limited and not always meaningful, specifically where people had dementia care needs.

Is the service well-led?

Inadequate

The service was not well led. There was no continuity in the management of the service due to the registered manager not being regularly present in the service. The current manager had not received all the information they required to manage the service on a day to day basis.

We found a number of concerns during our inspection which had not been identified by the provider or manager. This showed a lack of robust and effective quality assurance systems.

Records relating to the management and running of the service and people's care were not consistently maintained.

The Brake Manor

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection took place on 24 November 2016. The inspection team consisted of two adult social care inspectors.

Before the inspection we reviewed information held about the service and notifications of incidents we had received. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with Moreligh's operations manager, the manager on duty at The Brake Manor, five care staff, the cook and one member of the domestic staff team. Following the inspection we spoke with a health professional about the service.

Not everyone who was living at The Brake Manor was able to tell us their views about the care and support they received due to their health needs. We spoke with one relative and five people using the service. We also observed staff interactions with people.

We looked at care documentation for four people, medicines records, three staff files, training records, maintenance records and other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

Medicines were not being managed safely. The service was holding medicines that required stricter controls by law, known as controlled drugs (CD). We checked the records kept against the CD stock held at the service and found they did not tally. The CD ledger recorded a zero balance for a persons prescribed medicine. However we found there were seven doses of these medicines in stock. The medicine was dispensed in patch form. A box of four patches had been dispensed on 16 September 2016 and there were three patches remaining. In another sealed and unopened box there was a stock of four patches which had been dispensed on 22 November 2016. This meant the records were inaccurate. The person had been prescribed one patch to be administered weekly. Records of patches applied since September 2016 showed one patch had been applied on the dates, 19 September 2016, 9 October 2016 and 22 October 2016. This meant there were gaps of 20 days, 13 days and 33 days when there were no records of the patches being administered. This meant we could not be sure the person was receiving their pain relief medicine as prescribed.

Some people's medicines were either being used, or not returned to the pharmacist, after the expiry date. For example one person was prescribed eye drops. The eye drops stored in the medicines trolley, were dispensed on 28 August 2016. Administration records showed they were still being used from 28 August 2016 up to 31 October 2016. The directions on the box said they must be discarded four weeks after opening. There were still some drops remaining and being stored in the medicines trolley. Eye drops for one person which required cold storage had been opened on 20 September 2016. These eye drops were still being stored in the medicines fridge for this person. This showed medicines with expiry dates were either still being used or had not been returned to the pharmacist as required.

Some people had been prescribed creams and several of these had not been dated upon opening. This meant staff were not aware of the date when the cream would no longer be safe to use. There were regular gaps in all the records for creams where staff had not always documented when they had applied the prescribed creams. This meant it was not always possible to establish if people had received these medicines as prescribed.

The medicines fridge temperature was showing a temperature within the acceptable range of 2-8 degrees to store medicines. However there were no records being kept to monitor the fridge temperature. This meant staff may not be aware if the fridge began to not work effectively.

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

Risks associated with people's health and welfare were not being managed safely. Some people's health had deteriorated recently. One person had returned to the service following a hospital discharge. They were in bed throughout the inspection. This person had been issued with a pressure assessment record due to their skin deterioration and risk of pressure wounds developing. Between 10:30 and 17:15 both inspectors checked to see if the person's position had been changed and recorded. The inspectors noted a slight change of position at 14:30. There had been no record of this documented. In addition, it was noted this

person had received very little fluid which was in a beaker by the side of the bed. There was no record of food or fluid intake. This person's last review of care was in May 2016 when it was documented, "does not require any assistance from staff." This meant staff did not have the current up to date information to care for this person as their situation now required.

One person's health had been deteriorating for some time and a health professional told us they had only recently been made aware of this person's needs in order to carry out a health assessment. The person had experienced a weight loss of 10kgs in the period August 2016 to October 2016. Following this a risk assessment had been carried out which identified the need for food and fluid monitoring. The food and fluid chart seen showed there was a gap in records between 19 and 21 November 2016. There was no minimum daily amount recorded for staff to use as a benchmark. The largest daily amount of fluid recorded was 570mls, the lowest was 50mls. This meant the person's health and welfare was not being managed safely.

This contributed to the breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

During this inspection we identified concerns that the service did not have robust recruitment procedures in place. Three staff records were checked. The most recent employee had no record of the date they started working in the service. There was no evidence to show a Disclosure and Barring Service (DBS) check was in place at the time the staff member started work. DBS checks are used to help ensure staff are suitable to work in the care sector. Two other staff recruitment files showed one member of staff had started working at the service 10 days before a completed DBS check had been received and another 21 days before a satisfactory DBS check had been received. The failure to complete necessary checks before allowing staff to provide care exposed people to unnecessary risk. This meant the provider did not have the information required in respect of all employees as specified in Schedule 3(2) of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

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

There were some concerns with the environment seen during the inspection. These included, some water damage to a bedroom ceiling on the third floor. This room also had the top drawer missing from a chest of drawers. A room on the first floor had been a bathroom. The bath had been removed and the room was being used solely as a toilet. There was no floor covering in this room. Two hoists were being stored in the room which were also marked as requiring servicing by November 2015 but not has having taken place. Staff told us they were not being used. The room had a sliding door with no lock. A piece of plastic coated flex was tied around the handle which looked like it would be used to secure the door if the toilet was being used. This area was not safe to be used due to the equipment being stored in the room and low exposed pipes. Also, the lack of a suitable door lock meant anyone using it would not have their dignity and privacy adequately protected.

There were a number of items, including a disused mattress, being stored in the ground floor corridor. In addition there was a kitchen cupboard waiting to be collected and some wheelchairs. The maintenance record for 5 November 2016 also reported the need for 'rubbish to be removed. When he gets the van'. The bins at the entrance and rear of the service were overloaded with rubbish bags for collection.

There were five wheelchairs and six Zimmer frames stored in the hallway at the bottom of the stairs. Of these only one Zimmer frame was for a named person who was in hospital. This storage of chairs and mobility equipment reduced the amount of space in an area which was used as a main walk through and posed a potential hazard to people that used the service.

A mattress and bed was being stored in a person's room following delivery of a hospital bed on 30 September 2016. The maintenance record dated 5 November 2016 included reference to moving the bed and mattress from this room. It was moved during the inspection on 24 November 2016. This meant there had been a delay of 19 days during which the person had been occupying a room which was cluttered and did not offer a pleasant environment.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At this inspection we found the water temperatures of water running from hot taps was being regulated safely. All hot water being discharged from hand basins and baths was within the safe range as laid down by health and safety guidance.

The manager identified required staffing levels using a dependency tool to calculate the numbers of staff needed for each shift based upon the dependency levels of people using the service. The manager was able to request bank staff where necessary although none were being used in the service at the time of the inspection. The manager told us care staff levels had increased by one to cover the hours 8am-8pm. Comments from staff included, "It has helped a bit because residents needs are getting more demanding" and "There are more that need double ups (two staff to support one person) and having another staff (on duty) has made that a bit easier for us." While the number of care staff had increased the needs of people using the service were generally high. There were periods of time when no staff were available in the lounge areas. Also, due to the layout of the service it was observed it took staff some time to reach the third floor and the rooms along the rear ground floor corridor when call bells were used in these areas.

Fire alarms and equipment were checked by staff and external contractors. Service certificates for gas and electric appliances were not available to view at the time of the inspection. The operational manager told us they were held by the registered provider who was not available as they were out of the country.

Staff knew the action to take within the service, if they had any concerns or suspected abuse was taking place. They were aware of the whistleblowing and safeguarding policies and procedures, although as reported in the Effective domain in this report most training for safeguarding was out of date.

Requires Improvement

Is the service effective?

Our findings

Some of the areas of the building were in need of redecoration and maintenance. A weekly maintenance report was submitted to Morleigh group head office by the manager. The report dated 05 November 2016 included an issue also reported on in the 17 October 2016 report. This referred to a divan bed and clutter in the corridor outside room 36. We observed some of these items being removed on the day of the inspection 24 November 2016. The report of 17 October 2016 recorded 13 defects in and around the service. Some of the issues included a rusty ladder and a door coming off its runners, a faulty bathroom light bulb and broken towel rail, wallpaper coming off the walls, two corridor light bulbs not working and a leaking tap. None of these defects had any progress reported or a plan of action to address the faults. Some people had their personal possessions in place to give their rooms a familiar feel. However, many rooms were sparse with dim lighting, broken furniture and furniture which did not match. There was a general air of neglect throughout the building. This meant people were living in a service which was not being effectively maintained and was not beneficial to their emotional well-being.

This contributed to the breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Care plans contained risk assessments for a range of circumstances including moving and handling, nutritional needs and falls. Where a risk had been identified there was guidance for staff on how to support people in order to minimise risk and keep people safe whilst maintaining as much independence as possible. However, this information was not always up to date. For example, one person was confined to bed due to their health needs. Their care plan recorded pressure care records which were to be completed due to the potential risk of skin damage. The records were being recorded but not effectively. For example, some records indicated the person needed to be turned every two to four hours. This was not being recorded. Daily records from 12 November 2016 to 24 November 2016 only indicated the person had been repositioned 'am' or 'pm'. There were no specific times for when turns were recorded. The records required staff to record what position the person was in and the length of time the person had been in that position. This was not reported on at all. There was no evidence of how this information was being monitored. This meant we were unable to establish if the person was being cared for according to their needs and to protect them from the identified risk to their skin.

Some people were at risk of losing weight due to a poor appetite or being unable to eat independently. People were weighed regularly according to the guidance in their care plans. However, these weight records were not being reviewed regularly to ensure that any loss of weight was identified and action taken to address the concern. A health professional told us they were concerned that, where people's weight was fluctuating, this was not being reported.

This contributed to the breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

There was little signage which would support people to move independently around the service and

recognise bathroom, lounge and dining areas as well as their own rooms. This did not support the needs of people who were living with dementia, and may have needed prompts to help them to recognise their surroundings independently.

Staff had access to training in order for them to develop skills. Staff files included certificates for training which had been completed. Training in essential areas including moving and handling had recently been updated. Most staff had received dementia training and, where staff were responsible for medicine administration, they had certificates which were in date. However, the training matrix showed there were areas where staff training was out of date. For example, in respect of safeguarding training, of the 18 staff, 10 were out of date in this area and six were due to have refresher training. Also, staff had not received training in respect of completing a new risk assessment tool. This meant staff might not have had the necessary knowledge and skills to respond effectively to any suspected abuse.

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

The manager had been in post for eight days. They had not been involved in the service's induction programme. There were no records available to show what staff induction had taken place. Staff on duty at the time of the inspection had been in post for some time and were not able to confirm what the induction programme involved. They told us they had shadowed more senior staff before working on their own and had been shown some policies and procedures by the previous manager.

Staff told us they generally felt supported by the new manager but that due to recent changes in managers at the service, supervision had lapsed. Two staff files did not have any supervision records in place. One staff file had one supervision record. Staff files were loose leaf resulting in the information being difficult to find. There was a supervision matrix in place. This showed the previous manager and four of the care staff had not received supervision at all during 2016. Two staff had a recorded supervision session twice during 2016. This meant not all staff were receiving the level of support necessary to help them carry out their role and develop their learning.

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

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Management and staff were clear on the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS).

Management carried out assessments to see if there were any restrictions in place for people that might mean an application under DoLs would need to be made. Several people had DoLS authorisations and other applications were being processed.

We observed the lunch time period in the dining room. The cook was on sick leave on the day of the inspection and has since left the service. The manager brought in a cook from another service in the group. They had prepared the main lunchtime meal with little time available to them. Comments included, "It's not been as good as usual today" and "I have changed my mind and had the alternative." Other people told us they were not happy with the food in general. Comments included, "It's not really good even with a choice" and "Bland that's all I can say." Staff commented that the quality of the ingredients were not as good as they had been. They told us, "The tea bags and coffee are really poor quality. In general it's all about cutbacks." A member of the catering team told us there was a centralised ordering process which meant staff had no choice as to the food suppliers.

There was a daily alternative and due to the issues on the day of the inspection many people had made a choice of the alternative meal. Observations made during the lunchtime meal showed people were shown respect and consideration if they required support with their meal. There was a choice of drinks hot and cold with the meal at lunchtime.

Where people required support to eat their meal staff were available to them. Some people had their meal in their room. Staff checked on a person having their meal in their room to make sure they were happy with it and if they wanted anything else.

We recommend that the provider seeks people's views about the food provided and makes changes as appropriate to ensure people are happy with the quality of the food served.

Requires Improvement

Is the service caring?

Our findings

Not everyone at The Brake were able to verbally tell us about their experiences of living at the service due to their healthcare needs. In general staff took time supporting people and comments were positive. One visitor told us they were satisfied with the care their relative received. They said, "I don't have any concerns about (person's name)." Comments from people using the service included, "The carers are good. We have a bit of a laugh" and "Generally happy living here. There are always things that could be better."

Two people who were unable to move around independently were in chairs next to each other which reclined. For most of the morning they were sleeping. They remained in the chairs when being supported with their lunch. Staff were respectful and sensitive when speaking with them but there were periods of time when they were on their own without any environmental stimulation other than music playing or television. Neither of them appeared to be interested in either of these. Staff were only visible in the lounge area when they were supporting people with a drink or to move position. There was little meaningful communication between staff and people in the lounge area throughout the inspection. Staff told us this was because they were busy supporting people with higher needs in other areas of the service. The care and support we saw being given by staff in the lounge was largely task based. This meant people's social needs were not being met.

One person had a 'Do not resuscitate' notice displayed on their bedroom door. This information was also in the person's care plan and staff could not explain why it was on the back of the person's door to their room. Displaying this kind of personal information was inappropriate and did not protect the person's privacy and dignity.

Some bedrooms did not have any identification on the doors such as a number, the person's name or a picture to support people in recognising their own bedrooms. This meant it could be difficult for people living with dementia to orientate around the building and find their room.

People's appearance was generally presented in a way which showed they were cared for. For example, men were supported to shave if they chose to. After eating breakfast a staff member was supporting a person to remove food which had been left around their mouth. This was carried out in a respectful and dignified way. The staff member spoke with the person and asked their permission to support them to do this.

People were prescribed continence aids which met their individual needs. These continence aids were kept in people's rooms to help ensure they received the correct product. There was a dedicated continence professional linked to the service who responded to referrals made by the manager.

Staff were aware of the need to protect people's privacy. They were observed knocking on people's doors before entering. When people were being supported to move around the building, staff were seen to assist people with the minimum of fuss and in a reassuring manner. People responded positively to this support. People's bedroom doors were seen closed when care was being delivered. Generally staff were seen to assist people in a reassuring manner.

During the day of our inspection visit staff were observed to be supporting people sensitively. Staff told us, "It is really important for us (staff) to make sure everybody is well cared for. I always think of how I would want my relatives to be cared for. It's about being patient and giving people time" and "I always make sure residents with dementia are listened to because they cannot say what they want."

There were examples of good practice seen during the inspection visit. For example, where a person was at risk of falling, staff were able to respond in a sensitive and caring way to support them.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive care and support that was appropriate to their needs because staff were not always provided with up to date information about how to respond to their individual needs. For example, there were some gaps where no record of care was recorded by care staff. This had occurred where a person should have been repositioned every two hours in order to protect them from further damage to their skin. Staff were given the information through daily handover with the manager or senior staff but this information had not been updated in the person's care plan. The re-positioning records in this person's room had not been completed. A recent concern had been raised from a relative about staff not following care plan instructions for two hourly repositioning. The person no longer lived at the service. The evidence found during this inspection supported the relatives concerns as it was not possible to establish whether people had consistently received the care they required.

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

Staff were required to complete daily records of the care provided to each person. In order to do this staff removed all care plans from the office and completed the daily logs in the lounge area. However, there were occasions when staff needed to respond to call bells etc. This meant staff sometimes had limited time to complete the daily logs. In some instances staff told us they relayed information to colleagues verbally and relied on that staff member to record this. It is important information is recorded as soon as possible after the event by staff involved in the delivery of care in order to help ensure the information is accurate.

It is recommended the service reviews the way staff record daily log sheets so it is an accurate and true record.

The manager told us all care plans were currently being reviewed and updated. The manager had allocated this task to senior care staff while overseeing the process. A senior member of the care staff told us, "There have been a lot of changes and since the manager left not all the care plans have been updated." We observed one person's care plan was not accurate and did not reflect their current needs. This person had recently been readmitted to the service and their needs had changed. Staff told us they had been updated about the person's needs verbally by the manager. Another person had lost a significant amount of weight in a short timeframe. The records did not show what action had been taken to respond to the weight loss. For example there had been no referral to the person's GP even though staff were reporting a consistent weight loss. This meant staff were not taking action to mitigate risks.

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

People's involvement in the care planning and review process was limited due to their level of capacity. Two files showed where a person had consented to their care and welfare as well as being involved in the care review. There was evidence of the person, or where necessary their families, being given the opportunity to sign in agreement with the contents of their own care plan. Care files contained information sections to

record a range of aspects of people's support needs including mobility, communication, nutrition and hydration and health.

The service did not have a designated activities co-ordinator. The manager told us activities were limited and the service relied on staff to provide entertainment. During the day there was no evidence of staff engaging in any activities and people were sat in the lounge with either music on or the TV. Staff told us they were busier now because the needs of people living at the service had increased and this meant more time was spent supporting people with their health needs and less meeting people's social needs.

This contributed to the breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014

People were supported to maintain relationships with their family. Visitors were always made welcome and were able to visit at any time. Staff were seen greeting visitors throughout the inspection.

Inadequate

Is the service well-led?

Our findings

There had been recent changes in the management of the service. In September 2016 one of the two registered managers had resigned and cancelled their registration. The remaining registered manager had been working part time for three days a week. At the time of this inspection the registered manager was not on duty at the service. They arrived during the inspection and were advised the inspectors were carrying out an inspection. However they did not make themselves available to the inspectors at any point during the inspection. There had been concerns raised with the commission that the registered manager often brought their young child to work with them to work at the service and the child had on occasion been heard in the background during telephone calls with other professionals. This could not be verified during the inspection of the service. A manager recently employed by the Morleigh group had been in post for eight days at the time of this inspection. The manager was carrying out audits for all operational areas. We were concerned the arrangements for the management of the service were not effective. The newly appointed manager was not receiving the support needed from the registered manager in order to gain a thorough working knowledge of the service and people's needs.

Some people did not receive consistent or good care because systems to provide and monitor people's needs were inadequate. This included systems for food and fluid charts, use of observation charts and monitoring people's weight. These inadequate systems had led to poor outcomes for some people. For example, some people required regular observations by staff because they were cared for in bed. These checks were in place to help ensure they were safe, their personal care needs were met and that they had everything they needed. Despite these checks being in place for two people, as detailed in other areas of this report, their needs had not been met.

A health professional told us they had been working closely with the new manager in post in order to reassess a number of people living at the service. The health professional told us there was concern that some people currently being assessed had possibly been experiencing deteriorating health for some time but this had not been reported to them. It was clear people's health needs were increasing and therefore they needed more specialist care. We were concerned the systems and processes in place were not robust enough to ensure this increase in needs could be met.

There were no effective processes in place to develop the quality of the service provided. There were restrictions placed on the manager's autonomy to arrange meetings with staff. For example, a meeting arranged with the district nursing team and senior carers to discuss the recent introduction of a risk assessment tool to monitor pressure care, had been due to take place on the 5 December 2016. This had been cancelled by the provider. The manager had been told by the registered provider that no meetings could take place unless the registered provider was there and this date was not suitable. This meant staff were not having timely access to necessary training to support them in using assessment tools to manage risk safely. As a result of this lack of training the new assessment tools were not being completed accurately. This meant action to protect people from identified risk was not carried out effectively and efficiently due to the lack of information available to staff.

There was an agenda in place for a senior staff meeting dated 16 November 2016 but there were no minutes to confirm this had taken place. The agenda stated the meeting was to be about operational issues including medicine storage, receipt of medicines and pain management. As reported on in the safe section of this report we identified a breach of the regulations regarding the management of medicines and pain management. The meeting was also meant to raise issues with staff about the importance of reporting and recording. As reported on in the effective and responsive domains of this report, there were gaps in records where staff were not always recording information about people's care. This agenda demonstrated that the management of the service was aware of some of the issues that were making the service unsafe, but had been neither effective or responsive in resolving them. Although the meeting agenda indicated these were areas identified as needing highlighting to staff we could not establish if this meeting had ever taken place.

Audits had been taking place for maintenance however they were not effective. The records did not show what progress had been made with identified faults or when maintenance had been completed. Although the new manager had begun to audit and review all care plans this was overdue. For example one care plan had not been reviewed since May 2016 and the person's needs had changed considerably in the meantime. This was not evidenced from reading the care plan. A medicines audit had been completed in April and another in July 2016. There had not been an audit since then. The breach of regulation 12 found during this inspection highlighted that the service was not effectively monitoring medicines procedures. The operations manager visited the service but there was no report available to demonstrate the outcomes of these visits. The purpose of these visits was to check that quality assurance systems in the service were being completed. However, these systems had not been effective in identifying the areas of concern we had found at this inspection.

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

The Morleigh group carried out annual surveys to gather the views of people living in each service and their families. The manager told us surveys were given to people and their families to complete in November 2016. Information taken from surveys were collected and collated centrally at the provider's head office. However, the manager was not aware if the results were ready to be passed to the service. There was no other information from previous surveys available to the inspectors during this inspection. This meant there was a lack of evidence to demonstrate what if any action had been taken from previous survey outcomes to make improvements to the quality of the service provided.

The service had a complaints procedure, the details of which were in the entrance to the service. There had been a recent verbal complaint raised about the level of care for a person. The manager had responded to the concerns by working with other professionals to increase the level of support. However this was not included in the person's care records. We concluded that, due to the lack of clear oversight and leadership of the service, the systems and processes in place to help ensure and develop the quality of the service provided were not adequate.