Care Worldwide (Carlton) Limited

Newbrook

Inspection report

14 Carlton Avenue
Castleford
West Yorkshire
WF10 4BZ

Tel: 01977559233

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 1 and 2 May 2018. At the last inspection in August 2017 we found the provider was in breach of four regulations which related to safe care and treatment, staffing, person centred care and governance arrangements. At this inspection we found they had not made improvements and were still in breach of the same four regulations and an additional two regulations which related to safeguarding people against financial abuse and notifying CQC about significant events.

Newbrook provides care for up to three people who have learning disabilities. At the time of this inspection three people were using the service. People in care homes receive accommodation and personal care under a 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 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 service was not safe because risks were not assessed or well managed. We identified issues around fire safety. Incident forms were not completed even though daily records showed these were occurring on a frequent basis and there was no evidence action was taken to prevent similar issues from reoccurring. People were not receiving their personal financial allowance. Staff were not appropriately trained and supervised. There was a high turnover of staff and because only one member of staff was on duty for most of the time people had limited opportunities. Relatives raised concerns about the service. Medicines were managed safely.

People lived in a pleasant environment but the lack of communal space impacted on people's quality of life. People's health needs were not met because they did not always receive health checks and support from health professionals. The provider did not monitor if people's nutritional needs were met. Food records showed meals were not varied.

Support plans had been re-written but these were still not always accurate and did not reflect people's current needs. People had not been involved in the support planning process. One person planned their week and had the freedom to arrange activities which were based on their preferences and wishes. Others did not engage in person centred activities. Capacity assessments and best interest decisions around medicines, personal care and finances had been completed; other people had been involved in these processes. We have made a recommendation about Deprivation of Liberty Safeguards.

We observed friendly interactions. Two members of staff were mainly responsible for providing care to people during the day. We saw interaction by both staff and it was evident that people who used the service were comfortable with the staff who supported them. One person was excited and hugged the member of

staff when they entered the room. One relative told us staff were very kind.

There were widespread and significant shortfalls in the way the service was led. Some important records could not be located. Staff and resident meetings had not been held so people did not have opportunities to share their views. The provider did not have effective systems to assess, monitor and manage the service. They did not have processes to learn lessons and drive improvement. The provider did not respond to external reports.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014, which related to safe care and treatment, staffing, person centred care, governance arrangements and safeguarding people against financial abuse. We also found a breach of the Health and Social Care Act 2008 (Registration) regulations 2014 because the provider had not notified CQC about a serious injury incident.

The overall rating for this service is 'Inadequate' and the service therefore continues 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.

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.

Care was not provided in a safe way. Risks were not assessed and appropriately managed. People were not protected against financial abuse.

Staffing arrangements did not ensure people were safe.

Medicine systems were safe and people received their medicines as prescribed.

Is the service effective?

Inadequate

The service was not effective.

Staff did not receive appropriate training and support which ensured they were equipped to carry out their role and responsibilities effectively.

People lived in a pleasant environment but limited communal space impacted on their quality of life.

People were not enabled and supported to help make sure they stayed healthy.

Is the service caring?

Requires Improvement

The service was not always caring.

People who used the service were comfortable with the staff who supported them.

Staff gave examples of how they met people's wishes but guidance to help people express their views was not always followed.

Is the service responsive?

Inadequate

The service was not responsive.

Support plans did not guide staff on people's care and support

needs. The service had not taken steps to comply with the Accessible Information Standard.

People's individual needs were not met in relation to their hobbies and interests.

The provider had a complaints procedure but this was out of date and not accessible.

Is the service well-led?

Inadequate

The service was not well led.

There were widespread and significant shortfalls in the way the service was led.

The provider's quality management systems were not effective and did not identify areas where the service had to improve.

Opportunity for staff and people who used the service to share their views was limited.

Newbrook

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 inspection took place on 1 and 2 May. Day one was unannounced and day two was announced. Two adult social care inspectors carried out the inspection.

Before the inspection we reviewed the information we held about the service. This included information we had received about the service and statutory notifications sent by the provider. Information received about the service included whistle-blowing concerns about medicine errors, provision of food, record keeping and management arrangements. A professional also contacted us and told us they were concerned about care provision at Newbrook. We contacted relevant agencies such as the local authority 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.

We sometimes ask the provider to complete a Provider Information Return (PIR), which is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. On this occasion we did not request one and took this into account when we inspected the service and made judgements in this report.

During the visit we looked around the service and observed how people were being cared for. We spoke with all three people who used the service, two relatives via the telephone, four members of staff, the regional manager and manager. We gained limited information from some people who used the service about their experience of living at Newbrook because of the different ways they communicated. We spent time looking at documents and records that related to people's care and the management of the home. We reviewed three people's support plans. In the report we have referred to the regional manager and manager as the management team.

Inadequate

Is the service safe?

Our findings

At the last inspection we found risk was not always appropriately assessed and some information was out of date. At this inspection we found the provider had introduced new style risk assessments and support plans but this has not ensured risk was appropriately managed. For example, one person's care review records showed they were allergic to a particular ingredient common in food and drink. The review said if this ingredient was consumed it could trigger a seizure. There was no reference to this in the person's nutritional risk assessment. When we asked the staff member about this allergy they said all they had been told was the person had to avoid a certain type of drink. When we mentioned that this ingredient was common in other drinks and food and asked if the person could safely consume these; the staff member said they did not know.

It was evident from another person's care records they had been getting upset and distressed. The person's support plan was not followed and incident forms were not completed. The person was frequently refusing personal care and meals but staff were not monitoring or mitigating associated risks. A record stated the person had lost over one stone in weight over four months but staff and the management team at the inspection could not confirm if this was a recording error or an actual weight loss because they did not know the person prior to January 2018. We concluded the provider had not assessed or taken reasonable action to mitigate risk.

At the last inspection we found there was often tension between two people who used the service. We discussed the compatibility issues with the registered manager at the time, who agreed to carry out a formal review and involve others who were relevant. There was no evidence the situation had been reviewed. Both people still resided at the service and staff confirmed they still had a poor relationship and this impacted on their quality of life.

Environmental risk assessments had been completed however these had not been reviewed or updated; some since 2015, others since 2016. The member of staff who was on duty, and lone worked did not know the service had environmental risk assessments. We saw two portable heaters were in use in the conservatory, surrounded by a metal guard. One person told us the conservatory was cold in the winter and hot in the summer. On the first day of the inspection the top of the guard was hot to touch as the heater was on full. We saw a risk assessment had been completed in February 2011 for the use of portable heaters but had not been reviewed since October 2015.

We saw a risk assessment for lone working dated February 2011 and had last been reviewed in November 2016. This stated that when staff worked alone there would be a manager on call, staffing was to be reviewed to ensure it was safe for staff to work alone, to assess the behaviour daily of people who used the service and to ensure that staff were fully trained and deemed competent before they worked alone. We found these actions were not being followed.

We were told by staff and saw in some care records that accidents and incidents had occurred involving people who used the service and staff. A support plan review showed one person had fallen in December

2017 and February 2018. The review also showed the person had sustained a fracture in a separate incident in February 2018; however it was not clear how this injury had been caused. The regional manager was unable to find any accident reports for these events and no daily records for the person for February 2018. The management team were unable to tell us what had happened to cause this injury. A staff member told us they had been injured at work in March 2018 when a fridge door fell onto them. They said they had reported the accident and completed an accident form. The regional manager confirmed an accident report had been completed and sent this after the inspection. The staff member told us they had gone to the hospital because of their injuries. The staff member said the fridge door had been broken for a while and they had been told by another staff member that the door had come off before and hit one of the people who used the service.

We saw the premises were clean, and staff had access to equipment to help control infection, such as disposable gloves. Fire extinguishers and a fire blanket were in place and the fire panel was active. Checks had been completed to help ensure the building was safe, such as fire alarm, gas safety and electrical wiring servicing. However, we saw fire safety systems were inadequate because some staff had not received any formal fire safety training and a health and safety report from January 2018 identified there was a high risk because the kitchen door was not closing properly. We noted the door had not been attended to so the provider had not taken action to mitigate the risk. A folder containing information about what to do in the event of a fire was kept by the front door. This included a floor plan and fire safety information including an evacuation procedure. The evacuation procedure stated staff were to collect an 'emergency bag from the entrance'. We asked the staff member who was on duty if they could show us this bag. We looked in the entrance but there was no emergency bag; the staff member said they did not know anything about this as it had never been mentioned to them. We concluded the provider did not ensure the premises were safe to use.

Personal emergency evacuation plans (PEEPs) were in the folder, however, these were not up to date and did not reflect people's current needs. For example, one person's PEEP stated they were unable to walk unassisted or get out of a chair or bed unaided, yet we saw the person mobilising independently. The PEEP had last been reviewed in December 2017 and stated no changes. We concluded care was not provided in a safe way for people who used the service.

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

We spoke with three members of staff who regularly worked at Newbrook, the manager and regional manager. None of the team had worked at Newbrook longer than five months so were relatively new to the service. One member of staff who was team leader said they had originally applied to work at the service as a support worker but after commencing employment they were offered the position of team leader. They said they did not go through any formal assessment process when they were promoted.

One person who used the service told us they felt safe and received appropriate care and support. They accessed the community and used public transport independently, and said they kept staff informed about when they would return. Two relatives told us they had concerns about the service, which included the staffing arrangements. One told us they were concerned about the high staff turnover and said, "[Name of person] gets attached to staff and it's not good for them with all the changes."

At the last inspection we found the provider did not have appropriate staffing arrangements in place because only two members of staff were providing cover. Both members of staff alternated and covered a 24 hour period. They started their shift at 10am and finished at 10am the following day. During the night they

slept at the service between 11pm and 6am. Staff had concerns around the staffing arrangements and said they were not sustainable. In addition to assisting people with personal care the member of staff on duty was responsible for planning and facilitating activities, cooking and cleaning. At this inspection we found the provider had made some improvements but this was not sufficient to meet regulation. They had introduced waking night cover so staff no longer worked for a 24 hour period but day staff still lone worked five days a week between 8am and 8pm, and were responsible for assisting people with personal care, planning and facilitating activities, cooking and cleaning. Two days a week an additional member of staff provided one to one support to one person, which enabled them to go out. However, this meant the other five days people who required support to access the community did not get opportunity to go out. One member of staff said, "We can't go out Tuesday, Wednesday, Friday, Saturday or Sunday because there is only one care staff. They will send staff if anyone has a Doctor's appointment." We concluded the provider did not ensure sufficient numbers of competent, skilled and experienced staff were deployed at Newbrook.

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

Staff we spoke with said checks had been carried out before they were employed which included attending an interview. However, when we reviewed staff records we found recruitment checks were completed but not always robustly before people started working in the service. The application form for one recently recruited staff member showed gaps in employment. There were no interview records to show this had been discussed or explored and only one written reference had been obtained. Another staff member had only one written reference. The regional manager acknowledged these checks had not been completed and said they would take action to ensure appropriate checks were carried out in future.

Staff we spoke with said they would report any concerns to the management team and said they would contact CQC or the local safeguarding authority if they wanted to speak with someone outside of the organisation. The manager told us there were no open safeguarding incidents at the time of the inspection. Prior to the inspection concerns were raised with us about medication errors. The regional manager said the medication issues had been investigated and the conclusion was that there had been no administration error only a recording error. We saw the medicine administration record (MAR) confirmed this.

We checked systems for managing people's money and found this was not done safely. One person's care records showed they should receive £24.90 weekly allowance, yet their financial records showed they were not receiving this amount. Over a four week period the records showed the person had received a total of £44.00. When we asked the deputy manager about this they said the person had been receiving their weekly allowance up to March 2018 but since then had just been given odd amounts taken out of petty cash. The deputy manager told us the person's money was paid by their relative into a bank account held by the provider and the money was then withdrawn each week and held at one of the provider's other homes.

Another person went out independently into the community. Staff accompanied them when they withdrew cash for the week from the ATM using their bank card. The bank card and money was then held by staff. Staff then gave the money to the person throughout the week and recorded this on a personal money record. However, the person had not been asked to sign to confirm receipt. Bank statements were kept in the person's file up until August 2017. No-one knew where bank statements after August 2017 were kept.

We saw people's money was kept in an unlocked cupboard in the dining room. We saw one person's support plan stated they had a safe in their bedroom. However, when we checked with staff there was no safe provided. This person had no lockable facility in their bedroom. We concluded systems and processes were not operated effectively to safeguard people from financial abuse.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found people did not have medication support plans to guide staff around the care people required with their medicines. The registered manager explained new support plans were being introduced and these would cover medication. At this inspection we found medicine systems were safe and people received their medicines as prescribed. People's medicines were stored securely in individual medicine cupboards in their bedrooms. Room temperatures were checked to ensure safe temperatures were maintained. Systems were in place for ordering and returning medicines.

We observed the staff member administering the medicines to one person and this was done calmly and competently. The medicine administration record (MAR) was completed only when the staff member was sure the person had taken their medicines.

We saw MARs were well completed. Protocols were in place to guide staff in the use of 'as required' medicines. We checked one person's medicines and found the number of tablets left matched the record on the person's MAR.

The staff member told us no medicines were administered covertly (hidden in food or drink) and no one was prescribed any topical medicines such as creams and ointments. No one was prescribed controlled drugs (medicines subject to tighter controls because they are liable to misuse). There were no medicines requiring cold storage. Staff told us there was no medicine fridge but said one would be provided if needed.

Inadequate

Is the service effective?

Our findings

At the last inspection staff said they did not generally feel well supported in their role. The registered manager wrote to us after the inspection and outlined their plans for ensuring staff who worked at the service would receive more support from the management team. At this inspection we found the plans had not been implemented and staff did not receive appropriate support that enabled them to do their job well.

One member of staff told us they had started a few weeks before the inspection and had received an induction, however, it was evident at the inspection they were unaware of many important systems and processes that were relevant to their role. For example, they were unaware they had to complete incident forms, and did not know about the providers policies and procedures. We looked at the provider's training record which stated they had only completed one training session- 'care of medicines advanced'. The training matrix also showed other staff working at the service had not completed important training. For example, fire safety training, safeguarding adults at risk, data protection and moving and positioning (practical).

We looked at four staff files. Two of these staff had been recruited since January 2018 and there was evidence to show both had completed an induction. However, neither had any supervision records. Another staff member had started in November 2017 and had no supervision records. The fourth staff member had started working in September 2016 for the provider at another service and had only one supervision record dated July 2017. This staff member had no previous care experience and although there were training certificates on file there was no evidence to show they had completed the Care Certificate which is an identified set of standards workers adhere to. We saw medicine competency assessments for two of these staff. We concluded the provider did not ensure staff received appropriate training and support that was necessary to enable them to carry out the duties they were employed to perform.

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

One person told us they were asked by staff what they wanted to eat when the food shopping list was being prepared. They told us they followed a healthy eating plan and received good support and encouragement from staff.

At the last inspection we reported there was poor monitoring of meals served and the choice of meals was limited. A food record was available, however we saw this was not always completed. After the inspection the registered manager wrote to us and told us there would be a written menu planner and daily logs would include what people actually ate and what there was to choose from. At this inspection we found the provider had introduced a weekly menu planner but staff were not following these and only two weeks plans could be found.

A food safety record book showed records of food supplies coming into the home had been recorded regularly up until 12 February 2018. Since then only one entry was made on 14 April 2018 but this did not list

the items of food received. Temperature checks of hot food had only been recorded on five days through March and April 2018. We saw records of meals in the food safety record book but these showed a lack of variety. For example, chicken was served for tea on 12 occasions throughout April 2018. We concluded the provider was not monitoring whether people received varied meals and nutritional needs were being met.

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

We saw one person's nutritional support plan stated they needed to be supported to have a varied diet as they would often focus on having the same meal every day. The plan said the person had a folder with pictures and recipes in so they could choose their meals from this. We did not see this used at all during our inspection and although the regional manager told us this folder was available in the kitchen, the staff member on duty was not aware of this. We concluded the provider was not providing personalised care which enabled people to choose their meals.

People's health needs were not always met. Care records we reviewed showed evidence of access to some healthcare professionals but not others. For example, we saw one person had visited the dentist and optician. However, there was no information to show when they had accessed the GP or chiropodist. This person also had a medical condition yet there was no information to show how this was managed or monitored by healthcare professionals. Another person had a record to show staff had consulted a GP for advice when they refused to take medicines in January 2018 but there was no information about any other access to the GP. We saw they had a long toe nail but staff did not know if the person had seen a chiropodist. The person's health action plan was not dated so we could not establish when it was completed. The GP diary of health appointments was blank. The dental section stated they had a check-up in May 2016 but due to getting distressed had been advised to brush teeth morning and night. There was no evidence this had been followed up. The person had one health action which stated 'to work with staff to make a travel plan when an appointment is due.' One person told us they had recently visited the GP and optician but had not attended dental or chiropody appointments. They said, "I go to the doctors on my own but haven't been to the dentist for ages. The chiropodist used to come but not now. I don't know what happens." We concluded the provider was not enabling and supporting people to access relevant health professionals to ensure care is appropriate to meet their needs.

This is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we reported that some areas of the service needed decorating. The registered manager sent us a plan after the inspection which confirmed the areas for decoration and timescales. At this inspection we found most of the work had been completed and people were living in a pleasant environment. We saw individual rooms were personalised.

However, there was limited communal space because the service only had two communal areas, a conservatory and a dining room. Two people did not like spending time together in the same room. At the last inspection we reported at mealtimes they were positioned at the dining table so they did not sit next to each other and did not make eye contact. This meant a member of staff had to sit in between. The management team at the time said they would formally review the situation and liaise with funding authorities. After the inspection the registered manager wrote to us and confirmed the review had commenced. At this inspection we found the provider had not pursued the review and no-one had any knowledge of action that had been taken. Staff said the two people no longer sat in the same room for meals as one person ate their meals on their knee in the conservatory.

One member of staff told us there used to be frosted stick on cover on the doors between the conservatory and dining room to help prevent the two people from seeing each other. They said, "We were told to remove it but behaviours increased. We put curtains up on Sunday and it's been ok since." One person who used the service told us, "[Name of person] stays upstairs during the day and comes down when [name of person] goes to bed]." We concluded the provider had not assessed the risk of both people living together or taken reasonable action to mitigate risk.

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

The 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At the last inspection we reported people's support plans had some information about decisions they made such as when to go to bed and get up. The registered manager said they were introducing new support plans which would focus much more on decision making and consider people's capacity. Mental capacity assessments had not been carried out even though decisions were being made on people's behalf; the registered manager said these would be introduced. At this inspection we found capacity assessments and best interest decisions around medicines, personal care and finances had been completed and other relevant people had been involved in these processes.

One person's support plan showed they had a DoLS in place. When we asked staff if the person had a DoLS they said they did not know. Staff showed us a DoLS application dated 23 February 2017 but could not find any DoLS authorisation. The management team did not know whether the person had a DoLS authorisation in place. On the second day of the inspection the regional manager told us they had contacted the local authority as they had been unable to find a DoLS authorisation. They told us the Local Authority confirmed the person's DoLS authorisation had expired on 29 March 2018. The regional manager said they would be applying for a further DoLS. We recommend the provider introduce a system to ensure they are submitting DoLS applications in a timely way and staff are more familiar with the process.

The provider used standard care documentation at Newbrook for risk assessing and support planning. Support plans had three sections- 'this is what you need to know about the support I need, aims and objectives, and this is how to support me'. The support plan identified if a risk assessment was in place. People also had health actions plans and daily records of care. It was evident at the inspection the care recording and support planning system was not effective and it was unclear where some records were being stored. We were told some records, including recent entries, were kept at another of the provider's services but when we asked to look at some specific records they could not be located. This meant the provider could not assess and monitor risk and quality of the service.

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

Staff were also confused what they should be recording. One member of staff told us they recorded different aspects of the support plan on different daily records of care but a member of the management team said

this had changed. The regional manager said they had identified the current support planning and care recording format was complicated and not user friendly, therefore not effective. They said they would be introducing a new format and introducing better support to help ensure all staff understood the support planning, assessment and care recording process.

Requires Improvement

Is the service caring?

Our findings

At the last inspection we observed examples of good care practice and examples of poor staff practice where staff were not caring and did not promote people's rights and choice. At this inspection we observed friendly interactions and did not observe any examples where staff were not caring. Two members of staff were mainly responsible for providing care to people at Newbrook during the day. One person told us, "It usually just [name of staff] and [name of staff], and nights who work here. They are all nice." We saw both staff interact with people who used the service and it was evident that people were comfortable with the staff who supported them. One person was excited and hugged the member of staff when they entered the room. One relative told us staff were very kind.

Staff we spoke with told us the staff who currently worked at Newbrook had a caring attitude. They also gave examples of how they ensured people's preferences and wishes were respected. For example, one member of staff told us one person liked to get up early on a morning and another person liked to get up much later, and people's daily routines were very different because they reflected their preferences. We saw evidence that confirmed this on both days of the inspection.

Relatives we spoke with raised concerns about the service. One relative said they were not kept up to date or informed of what's going on. They said the staff changes 'were not good' for their relative. Another relative said, "I've got massive concerns about the place."

People's care records had information about what was important to them. For example, one person's stated their family was important and they regularly met them in Leeds for coffee. The person's relative confirmed this happened on a weekly basis. We saw guidance to help staff understand if people were happy. One person had a support plan that stated they had a pictorial activity planner to follow which they completed with staff for the following day. The person told us it was their planner but we saw during both days of the inspection it was not used; it had the incorrect day and the activities were not followed. One member of staff told us, "[Name of person] is not interested in the activity board. They don't want it." Another member of staff said, "Night staff do the activity board. I noticed it had Wednesday's date on it." The regional manager said they had identified support planning was not user friendly and would be introducing a new format. They said better support would be provided to help ensure all staff understood the support planning process.

One person told us they were empowered to make choices and did this independently, and went out most days, to work or meet others. They said, "I catch the bus on my own, go to work on my own. I sometimes watch TV in my room. I enjoy doing jobs around the house when I'm free."

Inadequate

Is the service responsive?

Our findings

At the last inspection we found people's care and support records did not identify how their needs should be met. Some information was relevant but other information was out of date and not person centred. The registered manager said new support plans would be introduced. At this inspection we found new support plans were in place but these were not always accurate and did not reflect current needs. For example, one person's support plan stated they must have structure and routine and without this they get into routines that are not 'good for me and I do things that are not in my best interest' and 'I watch the same TV programmes and object to others sharing the TV'. A member of staff told us the person had control of the only TV in communal areas. The support plan stated without structure the person would spend most of the day watching TV. We observed the person did this on both days of the inspection. The person had a support plan that stated they did not have male care workers supporting them with personal care. However, we were told there had been occasions when a male worker had been the only member of staff working at the service. Another person's support plan stated all their medicines were prescribed in liquid form. The support plan had been reviewed monthly and at each review over the last four months it stated the support plan was incorrect as the medicines were not in liquid form, which was confirmed when we reviewed the person's medicines. However, the support plan had not been updated.

One person was assessed as not having capacity to make decisions around personal care. We saw frequent entries in the person's daily notes that stated they were regularly refusing showers and hair washing. In the person's support plan there was no guidance around how this should be managed and no evidence to show others were consulted around how best to support the person. Another person had a bath most days and staff recorded the temperature of the bath. The records showed throughout April the bath temperature was recorded as 32°C, which is a low temperature for full body immersion. This person's mobility plan showed the physiotherapist had designed specific exercises for the person to do with staff each day after their bath. On the first day of our inspection the manager assisted the person to have a bath. Later we asked the manager if the person had completed their exercises after their bath. The manager said they did not know that the person had to do any exercises. We concluded people's care was not designed with a view to ensuring their needs were met.

We asked one person about how they were involved in planning their care and support. They said, "I have a care plan but I've not gone through it. I've not done any reviews. It was ages ago and I don't know what it says."

People's care records identified that they should have access to pictorial information to aid communication. However, there was very little easy read information which had simple language and pictures. The provider had a basic easy read complaint's procedure but the member of staff on duty did not know this was available because it was kept in a folder. Other policies were not available in an easy read format. Pictorial menus were not used to help people make choices.

At the last inspection we found people's activities and daily experiences were mainly determined by staff. The registered manager said person centred activity programmes would be developed with each person

when the new support plans were introduced. At this inspection we found people were not enabled to carry out person centred activities. One person's communication support plan showed it was important for this person to know what they were doing in advance so they did not become anxious. It said the person had a weekly planner which was completed with them on a Sunday so they knew what was happening in the week ahead. We asked staff for the planner and they did not know if one had been completed or where it was. On the first day of our inspection we saw a staff member arrived mid-morning and told the person they were taking them out to the provider's other home to watch snooker. We heard the person say, "I'm going to college at 12.15." The staff member checked with the manager who said to take the person and bring them back in time for college. The person went with the staff member however this was rushed and there was little consultation with the person to check they were okay with this decision. A care review in December 2016 identified that the level of social activities for this person needed to be improved, including the person being able to go swimming. When we asked staff about this they said the person didn't go swimming but this was something they were looking into. A member of staff told us another person 'liked going out on the bus' but they had travelled in cars for the last few weeks because their 'bus pass has snapped'. No-one could tell us if any consideration had been given to continue accessing the bus or if a new pass had been applied for. We concluded people's care did not meet their needs.

This is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person who used the service told us they were comfortable talking to staff if they had any concerns or were unhappy but did not know the provider had a formal complaint's procedure. The member of staff on duty did not know where the complaint's procedure was kept.

We found information about how to make a complaint which was kept in a folder by the front door; however this was not up to date or accurate. The complaint's process was dated January 2017 and referred to another of the provider's services, not Newbrook. The manager and regional manager details were incorrect as they referred to staff who had left. The regional manager said they had no record of any formal complaints being received since the last inspection. The management team agreed to update the complaint's procedure and make this accessible to people.

The provider had completed an audit against quality standards in March 2018. During the audit they identified that the manager responded to complaints and compliments appropriately and there was evidence to support this. However, they also noted that staff felt unable to raise concerns. There was no evidence to show any action was taken to address this. We concluded the provider was not improving the quality of the service.

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

Inadequate

Is the service well-led?

Our findings

At an inspection in July 2014 we found the provider was breaching six regulations. At an inspection in January 2015 we found the provider had addressed the issues and was meeting all regulations; they were awarded an overall rating of good. At the last inspection in August 2017 we rated the service as overall inadequate; two domains were inadequate and three domains were requires improvement. We found the provider was breaching four regulations, which related to safe care and treatment, staffing, person centred care and governance. At this inspection we found the provider was still in breach of the same four regulations and an additional two regulations which related to safeguarding people against financial abuse and notifying CQC about significant events. This demonstrates that there were widespread and significant shortfalls in the way the service was led.

At the last inspection we reported there was a lack of management presence and oversight. Visits by the registered manager and senior managers were infrequent. We were given assurance there would be significantly more management presence. At this inspection the service had a new management team; the manager had been in post two weeks and the regional manager eight weeks. A deputy manager, from another of the provider's services, visited during the inspection to assist with locating some records but told us they were not involved in the management at Newbrook. The management team had visited Newbrook prior to the inspection but both acknowledged they had not spent much time there. We concluded there was still a lack of management presence and oversight. The management team said they would be setting up structured management time and would be carrying out a full audit of the service.

We asked to look at minutes for staff and resident meetings that had been held since the last inspection. The management team told us these could not be located, and they were not aware that any meetings had been held. Staff we spoke with said they had not attended any meetings. The management team said they were not aware of any surveys/questionnaires that had been completed sine the last inspection.

At the last inspection we saw a range of audits were carried out but these were not effective because they did not identify key issues and either did not have actions plans or there was a failure to implement action points. At this inspection we found similar issues. For example, care plan audits carried out in February and March 2018 identified one minor issue. We found significant shortfalls with the support planning process. A catering audit in February 2018 scored 87%; no actions were identified. We found significant shortfalls around how the provider was monitoring nutrition. A financial audit had been completed in February 2018 which looked at the administration of people's personal allowance. The audit showed all three people's personal allowance was checked and no issues were identified. The audit scored 100%. We found people's money was not managed safely and therefore concluded the financial audit was not effective.

The provider had completed an audit against quality standards in March 2018. However, it was evident from the inspection they had not taken steps to improve the areas of concern which were identified as issues during the audit. For example, they had been unable to evidence if medical reviews were due, and were unable to evidence if incidents were reported and logged. They were unable to evidence if monitoring processes were in place around the risk of falls and were unable to evidence if family and friends were

involved. They noted there were gaps in the recording of people's activities and people had no planned activities for the day. There was no action plan even though issues were identified during the audit. We concluded the provider had failed to improve the quality and safety of the services provided.

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

Providers have a responsibility to notify CQC about certain significant events such as safeguarding, serious injury and police incidents. Before the inspection we checked our records and found we had received three notifications of abuse or allegations of abuse in the last 12 months. However, we did not receive a notification for an incident that occurred in March 2018. A support plan review stated one person had sustained a fracture as a result of a fall in February 2018, however it was not clear how this injury had been caused. The regional manager was unable to find any accident reports for these events and no daily records for the person for February 2018. We concluded the provider had failed to notify CQC of the serious injury.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2014.