Dryband One Limited

Newgrove House Care Home

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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Newgrove House Care Home is registered to provide residential care for up to 40 older people, some of whom may be living with dementia. Accommodation is provided over two floors with lift and stair access. The home is situated on the outskirts of the town of Grimsby. On the day of the inspection there were 22 people using the service.

The service had a registered manager in post. A registered manager is a person who has registered with CQC 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. Following the inspection we were informed by the operations director that the registered manager had taken the decision to step down and had left the service. The day to day management of the service would be undertaken by the operations director until a new manager was recruited.

We undertook this unannounced comprehensive inspection on the 19 and 20 July 2017. The last comprehensive inspection took place on 26 and 27 May 2016 and although no breaches in regulations were identified we rated the service 'Requires Improvement' for four out of the five key questions and rated the service 'Requires Improvement' overall.

Due to concerns found during the inspection regarding assessing and delivering person-centred care, managing risk, need for consent, notifying CQC of incidents, having an effective monitoring system and ensuring sufficient numbers of staff were deployed at all times, 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.

Following the inspection, we received an interim action plan. We also requested and have received weekly updates to assure us actions have been taken to address the concerns. We found multiple concerns and are considering our regulatory response. 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. You can see what action we told the provider to take at the back of the full version of the report.

We found there was inconsistency regarding the application of the Mental Capacity Act 2005. The provider and manager had not always followed best practice regarding assessing people's capacity and discussing and recording decisions made in their best interests.

People were left exposed to avoidable risks because steps had not always been taken to assess and mitigate risks to people's health and safety.

We found there were times when there were insufficient staff deployed to meet people's needs.

People had care plans in place, however, we found these were not always person-centred and missed important information regarding how staff were to care for them. The care plans were not always updated when people's needs changed. This meant that important care could be missed.

The quality monitoring system had not been effective in highlighting areas that required improvement such as the care records, risk management and consent to care. We found action had not been consistently taken in order to address these. There were discrepancies regarding the records of some people who used the service which made it difficult to check if the correct care and treatment had been delivered. We found where accidents had been logged, these highlighted specific issues but lacked analysis to ensure lessons were learned to prevent reoccurrence. The CQC had not always received notifications of incidents which affected the welfare of people who used the service.

We received mixed feedback regarding the leadership of the service, which had affected staff morale and the turnover of staff in recent months. Visiting health care professionals felt the communication at the home was not always effective; there were some delays with referrals and the implementation of their guidance was inconsistent at times. The operations manager was undertaking a review of each person's heath and care needs.

People liked the meals provided to them and there was sufficient quantity and choice available. Staff supported people to eat their meals in a sensitive way when required. We saw there were plenty of drinks and snacks available in between meals.

There was a range of activities for people to participate in and staff supported people's access to the local community.

We found people who used the service were protected from the risk of harm and abuse because staff had received safeguarding training and they knew what to do should they have any concerns.

Staff were recruited safely and employment checks were carried out before new people started work in the service. People received their medicines as prescribed and they were obtained, stored and recorded appropriately.

The majority of staff had received regular supervision from their line manager. Staff had access to a range of training. There were some shortfalls and delays with staff completing some courses or refresher training. We have made a recommendation about reviewing the staff training programme in relation to the quality of the induction training and timely access to courses.

People told us they were supported by caring and attentive staff who knew their needs and understood their preferences. Relatives we spoke with were complimentary about staff's approach and felt their family member's needs were met in a caring way. People told us and we observed they were treated with dignity and respect by staff.

There was a complaints procedure on display in the service and it was included in information given to people. Staff knew how to manage complaints and people spoken with felt able to raise concerns.

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 consistently safe.

Insufficient staffing levels meant there was a risk people's care and treatment needs were not always fully met. Risks to people's health and safety were not always assessed or well managed. People were also left exposed to avoidable risks relating to the maintenance of the building.

Staff knew how to recognise and respond to abuse and understood the processes and procedures to keep people safe. Staff were recruited safely.

Systems were in place for the safe management and administration of medicines. People received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

There had been inconsistent application of mental capacity legislation, which meant best practice guidelines had not always been followed when people lacked capacity to make their own decisions. Staff understood the need to gain consent before care and support was provided.

People had access to a range of healthcare professionals but we found some delays with referrals for assessment to them and the guidance they provided was not always followed consistently.

Staff had access to a range of training although there were shortfalls and delays with staff completing some courses or refresher training. The majority of staff received regular supervision.

Is the service caring?

Good

The service was caring.

Staff were observed as having a kind and caring approach and

people spoken with confirmed this.

People's privacy and dignity was respected. People were encouraged to be as independent as possible, with support from staff.

Confidentiality was maintained and personal records were held securely.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People who used the service had care plans but there were some areas of their needs that had not been identified. Not all the care plans provided enough directions for staff, they were not personalised and had not been updated if there were changes in people's needs.

People had access to a range of activities and the local community.

People felt able to complain and knew how to do so.

Is the service well-led?

Inadequate

The service was not well-led.

There were shortfalls in overall governance of the service and support and guidance for the registered manager. Inconsistent management of the service in recent months had impacted on staff morale and staff turnover.

The quality assurance systems were not robust in detecting issues and bringing about improvements.

The Care Quality Commission had not always received notifications of incidents which affected the safety and wellbeing of people who used the service. We have written to the registered provider about this.

Newgrove House Care Home

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 registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

This unannounced inspection took place on 19 and 20 July 2017 and was completed by an adult social care inspector who was accompanied on the first day by an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. A contracts officer from North East Lincolnshire Clinical Commissioning Group attended the second day of the inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This 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. The PIR was received in a timely way and was completed fully. We looked at notifications sent in to us by the provider, which gave us information about how incidents and accidents were managed. We also spoke with the local authority safeguarding team, and contracts and commissioning team about their views of the service.

During the inspection we used the Short Observational Framework Tool for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who used the service. We observed staff interacting with people and the level of support provided to people throughout the day, including meal times.

We spoke with eight people who used the service, six of their relatives and two visiting health and social care professionals. We also spoke with the operations manager, registered manager and a selection of staff; these included three team leaders, the administrator, two care workers, the cook, an activity co-ordinator

and the house keeper.

The care files for eight people who used the service were looked at. We also looked at other documentation such as incident and accident records and medication administration records. We looked at how the service used the Mental Capacity Act 2005 and Deprivation of Liberty code of practice to ensure that when people were deprived of their liberty or assessed as lacking capacity to make their own decisions, actions were taken in line with the legislation.

A selection of documentation relating to the management and running of the service was looked at. This included four staff recruitment files, the training records, staff rotas, minutes of meetings with staff and people who used the service, complaints and quality assurance audits. We completed a tour of the building and checked the environment.

Inadequate

Is the service safe?

Our findings

People who used the service told us they felt safe living at Newgrove and that it was clean and tidy. We received mixed comments about the staffing arrangements. One relative said, "There have been a lot of changes and sometimes there is not enough staff. They try and get cover from other homes but they are not always familiar with people's needs." Another relative said, "There always seems to be an adequate number of staff in attendance." Comments from people who used the service included, "Never enough staff, they're run off their feet, many need a lot of attention at mealtimes and in the morning", "They seem to be a short of staff at times, especially at night" and "We have to wait for the toilet during the night, we sometimes wait an hour or so, only two on you see and there are a lot of people." This person also told us they now only had a bath once a week due to the number of people at the service.

We were shown a list of staff that had left the service in the last four months and we found that nine staff had either resigned or been dismissed from their positions following investigations into their conduct. The operations manager explained they were aware some staff had left due to conflict with the manager. During the inspection two more staff handed in their notice. This confirmed high levels of staff turnover. The manager told us staff from the provider's other services locally had been working at the home to try and cover shortfalls whilst recruitment was underway.

During our inspection visit we observed there were not sufficient staff employed or deployed to meet people's needs. On the first day of the inspection, the call bells were ringing continually at times and staff seemed over stretched. There were occasions when staff were not able to provide the care people needed in a timely way due to being busy elsewhere in the home. We also observed staff were not always able to spend time in the sitting room and the behaviour of some people living with dementia impacted on others who became anxious and upset.

Past rotas showed there had been a number of shifts over recent weeks when the planned number of staff on duty had not been provided. In the six weeks up to our visit there had been seven occasions where there had not been the full complement of care staff on duty. The manager told us some of the staff shortfalls were due to short notice sickness and problems finding cover, but other staff considered the rotas were not planned properly due to the shortages of staff and cover for the shifts was not always sought in time. There were also ten shifts when a kitchen assistant had not been provided for the evening shift, which meant the care staff had the additional work of preparing and serving the evening meal. A member of staff said, "We just can't do everything with three staff on in the evenings, there are at least ten people who need the support of two staff." Another member of staff told us, "We really struggle to give people the care they need, especially when there are not enough staff on."

There were not sufficient numbers of suitable staff employed or deployed which meant there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the end of this report.

Following the inspection the operations manager confirmed they had reviewed the dependency levels at the

service and increased the numbers of staff on the evening shifts. They would continue to review the staffing levels on each shift and had also recruited a new kitchen assistant who was due to start work at the service.

Risk assessments were completed where areas of potential risk to people's general health, safety and welfare had been identified. However, we found the risk assessments in place had not always been updated in line with people's needs or accurately identified the level of risk. For example, one person's care records showed they had experienced regular falls over the last six months, and on two occasions had received medical attention for injuries sustained. We found their falls risk assessment had not been reviewed since January 2017 and only updated in July 2017 after a fall where they had sustained a fractured hip. An associated care plan for falls was only put in place in July 2017. This meant staff may not have accurate information about the person's current needs. Another person's records showed their risk of developing pressure damage had not been reviewed and updated although they had developed pressure damage.

Records for a third person showed the falls team had raised concerns in June 2017 that bed rails had been provided for a person who was at high risk of climbing over the rails, which could increase the height of any fall and therefore pose an increased risk of injury. The associated risk assessments for falls and bed rails did not identify such risk. Following a best interest meeting the bed rails were removed. Other interventions such as the provision of a specialist bed and falls mat were put in place to support this person's safety whilst in bed as directed by the falls team. This showed there were concerns about staffs understanding of some people's level of risk and protection of people's safety.

We found some risks associated with the premises and equipment which were not appropriately managed. The automatic closure device to a door to the stairway on the first floor was not working and the door was found open on three occasions. This posed a possible safety hazard for people living with dementia. The lift service reports from the last safety check completed by external contractors identified work to be completed. The operations manager could not demonstrate this work had been undertaken. The maintenance person completed regular safety checks on the bed rails in the service, but the records did not demonstrate what checks had been completed and we found not all bed rails in use had been included in these checks. Safety checks were not completed on the bed rails for a person who had recently sustained a skin tear from a bed rail which did not have a protector in place.

Steps had not been taken to assess and mitigate risks to people's health and safety which meant there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the end of this report.

People who used the service were protected from abuse and avoidable harm. Staff were aware of the different types of abuse that could occur and what constituted poor practice. Staff were able to describe the signs that may indicate abuse had occurred and understood their responsibilities to report any concerns and enable them to be investigated. In recent months the service had worked closely with the North East Lincolnshire safeguarding adults team (NELSAT) to investigate a number of safeguarding concerns. NELSAT confirmed all investigations were now closed and they considered the investigations had been thorough and appropriate action had been taken by the provider where necessary, such as staff training, supervision and disciplinary action.

During our visit we observed the team leader administering people's medicines and saw they followed safe procedures and ensured people had the time they needed to take all of their medicines. We found people received their medicines as prescribed. There had been some concerns regarding medicine errors in previous months and these had been addressed with checking systems introduced, which had significantly improved the recording of medicines.

The manager confirmed the pharmacy provider had completed an audit the previous week and recommendations had been made to provide pain relief medicine out of the monitored dosage system to reduce wastage. The pharmacist had also identified that fridge temperatures had been recorded outside of the recommended range for those medicines which required cold storage. We found action had been taken to reduce the temperature and monitor this more effectively.

The team leader described the ordering, storage, administration and return practices within the service. Medication administration records (MARs) were used to record when people's medicines had been administered. The MARs we saw were completed accurately without omission, which provided assurance people were supported to take their medicines as prescribed. All 'as required' medicines were supported by written instructions which described the situations and presentations when these medicines could be given.

We found staff were recruited safely with full employment checks in place prior to them starting work at the service. These included an application form so gaps could be explored, references, an interview and a disclosure and barring service (DBS) check. This included a police check and assurance that the potential candidate had not been excluded from working with adults at risk. These measures helped the provider make safer employment decisions.

We found the service was clean and tidy. Staff had completed training in infection prevention and control and cleaning schedules were available for domestic staff. The laundry had appropriate equipment and supplies to ensure soiled linen was washed correctly. The arrangements for storing clean linen had improved with the provision of additional storage on the first floor.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the 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. We found the application of MCA was inconsistent. Whilst we found some people had capacity assessments and decisions made in their best interest recorded when they lacked capacity, others did not.

Some people had restrictions in place such as bedrails and sensor mats however, their capacity to make these decisions had not been fully assessed and the decision to provide them had not been discussed and recorded as in their best interest and as the least restrictive option for people. One person who did not have capacity was receiving their medicines covertly (which meant the medicines were hidden or disguised in food or drink) and there were no records of any discussions with the person's relatives and relevant professionals that this practice was in the person's best interests. A care manager attending a client's review told us their client's care file was basic and did not include the MCA records they had provided on admission to support the decision to move to the service. They also said the file contained a capacity assessment record completed by staff following admission, which detailed their client did not have capacity although none of the sections had been completed.

Not working within the principles of MCA is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the end of this report.

People 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 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. At the time of the inspection, four people had a DoLS in place and the manager had made a further 11 applications to the local authority, which were awaiting assessment and authorisation. We found the manager had followed up applications with the local authority to check on their status.

During our visit staff were observed to ask people for consent before providing any care and support. The people we spoke with confirmed that staff did ask them for their consent before they provided them with any personal care and support. Staff were clear about how they obtained consent from people prior to carrying out care and support tasks. They said, "We get to know our residents really well and their preferences for care. We always give them a choice" and "We talk to residents and give explanations about their care. If they refuse we respect that. We leave them and go back a bit later, that usually works or a change of face. We never have to use any physical interventions."

People told us that they had access to various healthcare professionals. The relatives we spoke with were also assured that staff took action to contact healthcare professionals when it was necessary. One person

said, "They ring the GP quite a lot and ask for their advice."

Care files and staff communication books indicated people had access to a range of community health care professionals such as GPs, community nurses, including psychiatric nurses, dieticians, speech and language therapists, physiotherapists, emergency care practitioners, chiropodists and opticians. We received mixed feedback from health and social care professionals we spoke with about the timeliness of referrals when concerns had been identified. One social care professional considered the staff had to be prompted to follow up concerns about their client's weight and the concerns could have been reported earlier. A health care professional told us it was generally a good service. They said there had been concerns some months ago about the incidence of pressure sores at the service and they had provided support and guidance for the senior care staff about this. They considered improvements had been made with care provision and communication with their team. The incidence of pressure damage had reduced, but they felt some staff could still adopt a more proactive approach towards this aspect of care. We discussed this feedback with the operations manager, who confirmed they would complete a care needs reassessment for each person and ensure any concerns in relation to people's health and care was followed up.

People who used the service told us they liked the meals. Their comments included, "Beautiful, varied, cook is a little diamond, chicken curry yesterday was one of the best I've ever tasted"' and "Very, very good and plenty of it – sometimes a choice of two things at lunch but, generally, only one; never had a bad meal yet." We observed the lunchtime and tea time meal services and found the meals provided looked well-presented and people enjoyed them. Staff were attentive to the needs of people who required assistance. We also observed people were offered a range of drinks and snacks during the day. One person who was reluctant to eat their meals in the dining room was provided with a range of finger food options which they ate whist walking around.

We found one choice was usually prepared for the main meal at lunchtime although catering staff confirmed alternatives could be provided and we saw these were listed on the menus. Specialised diets were catered for such as fortified, soft and textured diets and low sugar alternatives. However, the kitchen staff did not always have access to written information about people's dietary requirements. This meant there was a risk that inappropriate food could be provided. The operations manager confirmed they would provide a white board and ensure copies of people's dietary needs and preferences identified on admission would be held in the kitchen.

Staff confirmed they received sufficient training to enable them to feel confident when supporting the people who used the service. The training records showed staff completed a range of essential training and courses about people's individual needs and conditions. We found there were some gaps on the training matrix record where staff had not completed courses or when refresher training was due. In the main the courses had been planned for and booked, but there were some delays due to the reliance on a specific training provider.

The home's induction process consisted of staff watching a range of DVD's, completing a brief exam afterwards and shadowing experienced staff. There was no evidence within the staff files to demonstrate the home followed this up with tests of competency. Records showed new staff had watched many of the DVD training programmes on the same day. We discussed whether this style of induction was robust enough, particularly for those staff new to the care sector. The manager told us one care worker had completed the Care Certificate (a national accredited induction programme) and in future all new staff without experience of working in a care setting, would also complete the course. Records also showed there were some delays with the provision of practical moving and handling training for new staff. The operations manager told us they planned to provide qualified in-house moving and handling trainers within the organisation, but in the

meantime this training would be prioritised to ensure new staff were competent in supporting people's mobility and effective in the staff team.
We recommend that the service review the staff training in relation to the quality of the induction programme and timely access to training courses.

We spoke with staff about the support they received either formally in supervision or informally through staff meetings and hand overs. Supervisions are meetings between a line manager and staff member to discuss any areas for improvement, concerns or training requirements. Some staff told us they did not feel supported and felt there was a blame culture when things went wrong. We checked staff supervision files and found most staff had accessed regular meetings but one member of staff had not had any supervision since their employment three months previously. The manager confirmed they had not received any formal supervision since their promotion a year before. The operations manager confirmed they were reviewing the current supervision and appraisal programme to ensure it was properly maintained.

Relatives of people who used the service said, "The staff appear to be well trained. I have seen them moving and handling residents and asking a resident to keep their foot raised to avoid swelling" and "The staff are very aware of their needs and look after everyone very well."

We found there had been some adaptations to support the needs of people living with dementia. There was some use of contrasting paint colours, photographs on doors and pictorial signage to provide orientation for people living with dementia. There was a themed salon for people to visit to have their hair and nails done.

Good

Is the service caring?

Our findings

The people we spoke told us they had positive relationships with staff and felt staff were caring. One person described staff as, "Excellent." Comments received from other people included, "Staff are caring, very helpful, often have a little chat – it's a hard job", "I'm treated as I request, they get to know me, know my little foibles", "Some people get upset and shout a bit, but the staff are always very patient and kind", "I like the home and staff treat me very well, they are caring and kind" and "Very good staff, they know what I want doing."

Relatives told us the staff were caring and friendly. One person said, "The staff are extremely approachable, very pleasant and caring. They seem to genuinely care about the residents as individuals." Another person described the staff as, "Helpful, friendly, and welcoming."

We spoke with health and social care professionals who had attended the service to complete care review meetings. They told us the families were all very happy with the support people were receiving. Health and social care professionals also had positive comments about the staff. They told us, "I have observed staff have a kind and caring approach" and "Interaction between staff and residents is positive. They [people who use the service] tell us they are happy and settled here and we can see that."

Although we observed staff were very busy and over stretched at times we observed staff tried hard to meet everyone's requests for care and support. On the first day of the inspection we found staff had little time to spend with people and care support was more task based, however improvements were noted on the second day. We observed staff treated people with dignity and respect. Throughout the inspection we heard staff speaking to people in an appropriate way, they used people's preferred name and altered the tone of their voice when encouraging or praising people. They offered people choices about their care support. Staff were aware of the appropriate values with regards privacy and dignity and could describe the steps they would take to ensure personal care was given in a dignified manner. Their comments included, "We help people to choose how they want their care and other things like their clothes, bathing, where they want to sit and what they want to do" and "We encourage residents to do what they can for themselves. We give them time and try not to take over. We close curtains and use towels cover people during personal care."

We saw staff engaged with people in kind and supportive ways. People approached staff with ease and affection and staff responded appropriately. Staff were sensitive in their approach to caring for people living with dementia and they were skilled in calming people and providing distraction when people became agitated. For example, when one person became anxious and upset, staff noticed and sat with them, held their hand and actively listened to what the person was saying, staying with them until they felt more reassured. People were acknowledged by name and staff used friendly facial expressions and good eye contact when speaking with them. When people were seated staff knelt or bent down to speak with them at face height and eye level.

We saw people were comfortably dressed and they were supported with their personal appearance. For example, people had well laundered clothes, their nails and spectacles were clean and their hair had been

brushed. Some of the ladies chose to carry handbags with them and wear jewellery. Staff complimented people on their appearance.

People were provided with equipment, such as walking aids, to enable them to retain their independence. Staff we spoke with described how they supported people to remain independent and we observed this happen.

The care plans we looked at contained a limited amount of information about the way in which people preferred to be supported, but we found staff had a more detailed understanding of people's preferences, likes and dislikes than was recorded. We found the service worked within the principles of the Equality Act 2010 to ensure people were not treated unfairly because of any characteristics that are protected under the legislation. Information in relation to disability, age, religion, gender and sexual orientation was gathered through assessment to ensure any necessary support was provided and discrimination was not a feature of the service.

We saw people who used and visited the service were provided with a range of information. Leaflets were provided in reception about safeguarding, how to complain and advocacy arrangements. Records showed one person was currently receiving support from an advocate. An advocate is an independent person who can support people to speak up about the care service they receive.

We saw staff maintained confidentiality. They completed telephone calls and discussions about people's health care needs in private in the office. People's reviews were held in their bedroom or a quiet area. People's health and care files and medication administration records were held securely.

Meetings were held for residents and relatives in order to gain their input and views of the quality of the service. People who used the service, their relatives, staff and professionals were also involved in completing questionnaires about their experience of the service and any improvements they would like. We found the results of recent relative surveys were generally positive about the service and the information was posted on the notice board in the entrance hall.

Requires Improvement

Is the service responsive?

Our findings

The people we spoke with told us they did not always receive person-centred care and felt this was because staff were often too busy. One person told us the recent staff changes had affected continuity of care, they said, "Such a turnover of staff, so they don't always know how I like it [care delivery]." Another person commented that they would like staff to sit and talk with them more but added that they couldn't do so because staff were often too busy elsewhere.

We found some concerns in the assessment and care planning processes within the service. Each person who used the service had an assessment, risk assessments and a care plan, however, we found areas of need which had been identified but lacked a care plan to guide staff in how to support the person. For example, one person had a specific health condition and had been prescribed medicines for this by their GP. Their health need was not included in a care plan and there was little evidence of how this was monitored and when staff should report concerns. Staff were completing behaviour monitoring records for two people which showed they regularly exhibited behaviour which challenged the service, but there were no care plans in place to direct staff on the positive behaviour support both persons required.

Some care plans had detailed information about how to support the person in a person-centred way but this was not consistent throughout all the care plans we looked at. Some care plans did not have sufficient information, some had not been updated when the person's needs had changed and some information was spread throughout several planned areas rather than one specific plan. For example, one person had experienced weight loss and the person's GP had advised staff to provide a fortified diet. However, the care plan had not been updated. There was no clear care strategy in place that detailed the calorie intake to be achieved, the person's likes and preferences and how to encourage food intake in order to guide staff in supporting the person to gain or maintain weight effectively. Another person's needs around swallowing had been assessed by the speech and language therapist, yet the assessment report was not in the file and the care plan had not been updated to direct staff on the specific fluid and positional requirements needed to prevent problems with aspiration.

We found shortfalls with records to support pressure damage prevention. Records showed one person had sustained pressure damage some months before and this had healed. Although their risk assessment indicated they were 'high' risk there was no care plan in place to direct staff on the care the person required. We also found pressure relief charts did not always indicate the required frequency or the level of risk, and therefore it was difficult to audit if what was recorded was actually in line with risk management. We also found some people were not always weighed at the frequencies detailed in their care records in line with their assessment.

Not ensuring people's needs were properly assessed and failing to ensure care was thoroughly planned to ensure those needs were met was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the end of this report.

Following the inspection the operations manager confirmed they intended to introduce new a new care recording format. Each person's needs would be reassessed and new care plans would be produced.

The service employed an activities co-ordinator and people were encouraged to join in a range of social and leisure activities. The activity co-ordinator maintained a file which included a programme of daily events, this was also displayed on the notice board in the hall and we were told it could be subject to change if people wanted to do something else. We observed group activities and one to one sessions took place with people to ensure there was social stimulation and involvement. On the first day we saw people played Bingo and listened to music. The range of activities included, gardening, craft work, dominoes and other games, skittles, famous faces game, reminiscence and chair based exercises. The activity file showed some people had participated in outings to a local restaurant, garden centre, shops and a zoo in Cleethorpes. Entertainers also visited the service, such as singers and a dance group had performed in the garden the week before. The activity co-ordinator told us they were trying to develop more links with the local community and groups such as the rainbow guides had visited and planted some flowers. The activity coordinator also said they tried to ensure people who remained in their bedrooms had one to one attention which could involve sitting and chatting to them, looking at photographs or hand and nail care.

People we spoke with told us they could participate in activities when they chose to. One person told us they preferred to spend most of the time in their room. They said, "I'm a private person and don't like to get involved. I'm quite happy as I read a lot.'' They went on to say they had gone into the garden to watch the visiting dance group recently, which had been very good. Other people said, "I go into the lounge and listen to the music and we have a sing song now and again. I go the hairdressers once a week and I watch a lot of television, which I did at home" and "I play bingo, do gardening, do puzzles and we went to Cleethorpes one day."

There was a complaints procedure which was displayed in the service. This described how people could make a complaint and how to escalate it if required. People were provided with a copy of the complaints procedure in the service user guide on admission to the service. The staff had access to a complaints policy and procedure to guide them in how to manage complaints. This included letters for acknowledgement and forms to record the details of the complaint, investigation and outcome. Records showed the service had received four formal complaints since our last visit. Although the issues had been managed appropriately and resolved, we found the complaints file did not contain all the relevant acknowledgement and outcome letters, sent to complainants. The operations manager confirmed the files would be audited and the records retrieved and filed correctly.

Inadequate

Is the service well-led?

Our findings

During this inspection, we had concerns with the overall governance of the service. The service had a registered manager who had been in post a year and this was their first management position. The operations manager had been appointed in January 2017 after the previous one had resigned. We found the manager had not received adequate support or direction from the provider to ensure they were competent and effective in their management of the service. They told us they did not feel supported in their role. We also found staff lacked leadership, support and oversight from the manager. Issues around staff morale and conflict with the manager had led to staff leaving in recent months and a high staff turnover. Shortfalls in the management of the service had impacted on aspects of the safety, health and welfare of people who used the service.

Staff described the difficulties they had experienced in recent months and the low morale. One member of staff explained how the manager had continued to delegate additional management and administration responsibilities in relation to auditing, staff supervision, a lead role and care documentation which they struggled to complete alongside their duties in managing the shift and supporting staff with personal care. Comments from other staff included, "The manager doesn't support you as a manager and doesn't help out on the floor. Problems don't get sorted" and "It is very up and down here. So many staff have left. We try to keep up the standards of care but it's hard with all the recent staffing changes and we don't get much support."

A new quality monitoring system had been provided but we found this had not been implemented fully and the programme had not been effective in identifying shortfalls in the service or whether they were addressed in a timely way. Although regular audits had been completed on people's care files, we found shortfalls in the quality of the care records and records to support consent to care, which had not been identified through the audit programme. An assessment of each person's dependency levels was completed each month to support the calculation for the staffing hours needed in the service. We found some people's dependency scores were not accurate, which had affected the staffing hours provided. A pressure care audit completed in April 2017 only collated the overall incidence in the service and did not review whether the pressure damage was acquired in the service, the location and grade of damage or the equipment and care support in place.

The community matron for tissue viability completed an audit of the recording systems to support pressure damage prevention on the 22 February 2017. Some shortfalls were found by the community matron with the consistency of the care records when re-evaluating service user's at risk. No action plan was put in place following this audit to support the improvements needed and further shortfalls were identified during the inspection.

We could not locate any environmental audits which looked at the condition of the décor and furniture. We observed areas of the service appeared tired and in need of refreshing. A refurbishment programme had been developed for 2017 but we found this did not include all the improvement work needed or timescales for completion. Equipment was serviced and the maintenance staff completed regular safety checks but it

was unclear when some issues were identified, whether they had been addressed. We found improvement works to the lift and fire safety doors identified by external professionals/ contractors had not been completed. The operations manager followed this up during the inspection.

We found accidents and incidents were collated and documented but there was no overall analysis of accidents and incidents to identify any emerging trends or patterns to inform risk management, prevent reoccurrence or identify any learning needs.

The operations manager had completed a home audit on 3 May 2017. The overall result of the audit was a score of 52% and shortfalls were found in all areas checked. An action plan had been put in place by the operations manager that included 41 recommendations. A recommendation was made that the manager complete all future quality monitoring audits and follow up any outstanding improvement work previously identified. We found the manager had continued to delegate the completion of audits to other staff in the service and did not oversee the quality of the audits undertaken. The timescale for completion of the improvement work was the 30 May and June 2017 and we found many areas had not been addressed.

Not having systems in place for good governance is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had concerns about effective recording within the service. There were shortfalls in recording the assessment and care planning for people. Information was hard to track and obtain. The majority of up to date and key information was held in the senior communication book and not in people's care files. We found the recording of monitoring charts for fluid intake was inconsistent. Staff did not 'total up' intake and output and there was no optimum amount of fluid indicated for care staff to encourage service users to aim for. There were gaps in the charts for monitoring food and fluid intake and bathing. Some accidents and incidents were recorded in daily notes or a communication book but not on incident records, which meant the manager could be unaware of them and they may not be included in analysis and action plans to address or learn from them. A team leader told us they had completed an incident record with regards to an incident between two people who used the service, they had posted this under the manager's office door, but this could not be located.

Not maintaining accurate, complete and contemporaneous records is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meetings were held for residents and relatives in order to gain their input and views of the quality of the service. People who used the service, their relatives, staff and professionals were also involved in completing questionnaires about their experience of the service and any improvements they would like. We found the results of recent relative surveys were generally positive about the service and the information was posted on the notice board in the entrance hall.

We had received notifications when people had serious injuries, applications for deprivation of liberty safeguards had been approved or when people had died. However, we found there had been two occasions when the Care Quality Commission (CQC) had not received notifications of safeguarding concerns about incidents that had occurred between people who used the service. Although we were satisfied that appropriate action was taken to keep people safe, it is important we receive timely notifications for these incidents so we can monitor the amount of them and check with the registered manager how they are supporting and protecting people.

Not notifying us of incidents which affected the safety and welfare of people who used the service is a

breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. On this occasion we have written to the provider reminding them of their responsibility regarding notifications to CQC.

On the second day of the inspection we spoke with the operations manager about the concerns we had identified with the management of the service. They gave us assurances that immediate action would be taken to secure and improve the management of the service. Following the inspection we were informed the manager had stepped down and left the service. The operations manager had taken over the day to day management of the service and would be accessing additional support from other managers and senior staff in the organisation, to complete all the necessary improvement work. They provided a comprehensive action plan from the feedback provided at the inspection and intended to update this on a weekly basis. We have subsequently received an action plan and weekly updates on progress. The provider also agreed to a voluntary suspension of new admissions until systems could be improved. This has shown us the provider has taken our concerns seriously and has taken steps to address the shortfalls.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People who used the service did not consistently have their needs assessed, care planned and met in a person-centred way. Regulation 9 (1) (a)(b)(c) (3) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Capacity assessments and records of best interest decisions were not in place to support staff were acting lawfully in relation to aspects of people's care and treatment. Regulation 11(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health and safety were not appropriately assessed and steps to mitigate any such risks had not always been taken. Regulation 12 (1) (2) (a) (b) (d) and (e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons

were not always deployed in order to meet people's needs. Regulation 18 (1).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems or processes to assess, monitor and improve the quality and safety of the services provided and mitigate risk had not been operated fully. There were shortfalls in recording systems. Regulation 17 (1) (2) (a)(b)(c)(e)(f)

The enforcement action we took:

We issued a Warning Notice.