Girlington Nursing Home Limited

Britannia Care Home

Inspection report

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West Yorkshire
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Britannia Care Home is a purpose built facility in Girlington, Bradford close to local amenities. The home provides accommodation for a maximum of 35 people who have mental health needs. Accommodation is provided across three floors. There is clear access to all floors for wheelchair users with a passenger lift and a ramp for wheelchair access at the front of the home.

We inspected the service on 16 August 2016. This was an unannounced inspection which meant we did not give the provider notice of our visit. At the time of the inspection there were 31 people living in the home.

A registered manager was in place. 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.'

At the last comprehensive inspection in December 2015 we identified numerous breaches of regulation, rated the service as' inadequate' overall and placed it in special measures. At this inspection we found improvements had been made driven by a service improvement plan. Increased management support had been provided. As a result we withdrew the service from special measures.

People and staff we spoke with told us the service had improved and they were satisfied that good quality care and support was now provided to people.

However we identified some concerns regarding the way medicines were managed. One person had not been taking their evening medicines and satisfactory steps had not been taken by the service to protect this person from harm. We found other people's medicines were better managed.

People told us they felt safe whilst using the service. Risks to people's health and safety had been assessed and clear and person centred risk assessments put in place which were well understood by staff.

Sufficient staff were deployed to help ensure safe care. Additional staff were deployed if required to manage distressed behaviour. Robust recruitment procedures were in place to help ensure staff were of suitable character to work with vulnerable people.

The premises was suitably maintained and checks were regularly undertaken to ensure it was in a safe condition.

People told us staff were suitably skilled to care for them. Staff had received a range of training with further training planned over the coming months to address identified shortfalls.

A range of food was provided to people based on their individual likes, dislikes and cultural preferences. The

risks associated with malnutrition were appropriately managed by the service.

People had access to a range of health professionals. However the recording of health professional visits needed to be made more robust to make clear the outcome of appointments and visits.

The service was acting within the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People told us staff were kind and treated them with dignity and respect. This was confirmed by our observations of care and support.

Information on people's likes, dislikes and histories had been obtained by the service. Staff demonstrated a good understanding of people they were caring for. This helped ensure personalised care was provided that met people's individual needs.

Care records demonstrated that people's needs had been assessed and clear and person centred plans of care put in place. These were well understood by staff, giving us assurance that appropriate care was being provided.

An improved provision of activities had been put in place. A new activities room had been set up and regular trips out into the community took place.

A system was in place to log, investigate and respond to any complaints received.

Since the last inspection, improvement plans had been effective in raising the overall quality of the service. Systems were in place to assess, monitor and improve the service with a range of audits and checks undertaken. However medicines management audits were not sufficiently robust as they had not identified the issues we found during the inspection.

We found an open and inclusive culture within the home and staff told us morale was good.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

We identified the service did not manage medicines to one person in a safe way.

Risks to people's health and safety had been assessed and clear and person centred plans of care put in place. This included clear plans on how to reduce distress behaviour.

There were sufficient staff deployed to ensure people received appropriate prompting, supervision and support. Robust recruitment procedures were in place to help ensure staff were of suitable character to work with vulnerable people.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Since the previous inspection, training provision had been improved. This was still work in progress with staff due to complete further courses within the coming months.

People's nutritional needs were met by the service. People had access to a variety of food and drink which was well received by people.

People's healthcare needs were assessed and people had access to a range of health professionals. However the recording of visits of health professionals needed to be more robust.

Is the service caring?

Good

The service was caring.

People told us that staff treated them with kindness, dignity and respect.

Care records demonstrated people's likes, dislikes and personal preferences had been sought in developing appropriate plans of care. Staff knew people well and how to support them.

The service listened to people and used their views to make changes to their care and support.

Is the service responsive?

Good

The service was responsive.

People's care needs were assessed and clear plans of care put in place to help support them to develop or maintain good health.

People had access to a suitable range of activities which met their individual preferences

People were encouraged to raise concerns and complaints. Complaints were investigated and responded to the service.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People and staff said the new acting manager had improved the way the service was managed. A number of improvements had been made to the service and systems to assess and monitor the service were now more robust. However medicine management audits had failed to identify the concerns we found during the inspection.

Systems were in place to seek people's feedback and use it to make positive changes to the service.

Britannia 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 see whether improvements had been made following the service being placed in special measures following the December 2015 inspection. We looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

The inspection took place on 16 August 2016 and was unannounced. The inspection team consisted of two adult social care inspectors, a special advisor in mental health and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Two interpreters who spoke South Asian languages also accompanied us on the inspection to ensure we could speak with a diverse range of people within the home.

We used a number of different methods to help us understand the experiences of people who used the service. We spoke with ten people who used the service. We spoke with the registered manager, acting manager, three senior care workers, two care workers and the cook.

We looked at five people's care records, medication records and other records which related to the management of the service such as training records and policies and procedures.

As part of our inspection planning we reviewed the information we held about the home. This included information from the provider, notifications and contacting the local authority contracts and safeguarding teams. We also spoke with a health professionals who worked with the service.

We asked the provider to complete 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. This was completed and returned to us in a prompt manner and we took the information provided into account when we made judgements in this report.

Requires Improvement

Is the service safe?

Our findings

We found some good medicine management practice. However this was not consistently the case. We asked a nurse about the safe handling of medicines to ensure people received the correct medication at the right time. Answers given along with our observations demonstrated medicines were not consistently administered in a competent manner. For example, on three occasions we witnessed people being administered Lansoprazole; the medicine data sheet gave clear instruction it had to be administered 30 to 60 minutes before food yet on all occasions it was administered after food.

Scrutiny of the current medicine administration record (MAR) showed one person was not receiving their prescribed medicines as directed. Current records showed the evening dose of two of their medicines had not been administered either because of refusal or being asleep on 16 out of the last 19 days. We asked to see recently archived MAR sheets and scrutinised the periods 5th May to 1st June 2016 and 30th June to 27th July 2016 which represented 56 days. During that period these medicines had been administered on only nine occasions. We looked at the electronic care plan for the person's medicines. Actions required by staff was to ensure the MAR sheet was up to date and to inform the GP if the person did not take their medicines. Whilst the care plan recorded the GP had been informed of the person's refusal to take medicines it made no mention of staff actions should the person be found to be asleep or that the GP had been informed the person was commonly asleep when the medicine was scheduled to be given. The National Institute for Health and Care Excellence (NICE) document "Managing medicines in care homes guideline (March 2014)" makes two recommendation which were not being adhered to. Firstly under recommendation 1.14.1 care providers should have a policy statement on what to do if people are asleep at the time of planned administration to ensure people have their medicines. Secondly recommendation 1.14.4 says care home staff and pharmacists should agree with people the best time for them to take their medicines. Following the inspection the provider told us they had requested an immediate review of this person's medication and updated medicine policies and procedures to prevent a similar issue occurring.

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

We found other people's medicines to be better managed with evidence other people were referred to their doctor when issues in relation to their medication arose. We saw one person was prescribed Methadone. A specific policy was in place to ensure safe administration of the medicine and minimise the risks of illicit or illegal use this being and important matter to prevent diversion of methadone on to the black market.

We inspected medication storage and administration procedures in the home. We found the storage cupboards were secure, clean and well organised. We saw the controlled drugs cupboard provided appropriate storage for the amount and type of items in use. Medicine fridge and room temperatures were taken daily and recorded.

Some prescription medicines contain drugs which are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs. We saw controlled drug records were accurately maintained.

The giving of the medicine and the balance remaining was checked by two appropriately trained staff.

Creams and ointments were prescribed and dispensed on an individual basis. The creams and ointments were properly stored and dated upon opening. All medication was found to be in date.

Staff were aware of the need to ensure people prescribed certain medicines had regular blood tests. For example some people were prescribed Clozapine which can cause a serious decrease in the number of white cells (agranulocytosis).

We saw all as necessary (PRN) medicines were supported by written instructions which described situations and presentations where PRN medicines could be given.

We carried out a random sample of supplied medicines dispensed in individual boxes. We found on all occasions the stock levels of the medicines concurred with amounts recorded on the MAR sheet. We examined records of medicines no longer required and found the procedures to be robust and well managed.

One person had their medicines administered covertly. An examination of the person's care records showed correct procedures had been applied to ensure the medicines were administered within current guidelines. We saw meetings had occurred involving the GP, family members, a psychiatrist, care staff with personal knowledge of the individual and a pharmacist. Documents demonstrated a clear treatment aim of covert medication along with the required benefits to the person's health.

People we spoke with said they felt safe in the home. They said staff treated them well and did not raise any concerns. One person told us "I am very happy here; they keep me warm, well fed and safe." Staff we spoke with also said they had not witnessed anything of concern and were happy with the working practices within the home. There was a system in place to protect people from the risk of abuse. Staff had received training in safeguarding and those with whom we spoke were able to demonstrate their understanding about the different types of abuse that could occur. They were also able to explain how to report concerns within the organisation and knew how to raise a safeguarding alert. We saw evidence safeguarding procedures had been followed where incidents had occurred with appropriate preventative measures put in place to prevent a re-occurrence. Safeguarding was also discussed at staff meetings, supervisions and resident meetings. This helped provide opportunities for people to raise concerns. Where staff practice had been identified as a factor in any concerns raised, disciplinary processes had been followed to keep people safe.

At the previous inspection in December 2015, we identified a number of areas where potential risks to people's health and safety had not been appropriately assessed, monitored and mitigated. This included managing the risk of self-harm, behaviours that challenge and substance misuse.
At this inspection we found improvements had been made. The management team had reviewed existing risk assessments and made a number of changes and additions. We found risk assessments were more person centred and provided detailed information to staff on how to reduce the risk to people's health. For example, with regard to nutrition, continence, moving and handling, pressure sores and falls. We saw the risk assessments included information about the actions being taken to manage or reduce the risk. Assessments also considered people's mental health needs and how the risks posed to themselves and others were to be managed. This information was also displayed in the offices so it was easily accessible to staff. We also saw some people had a history of suicidal thoughts or actions resulting in self-harm. Risk assessments included the identifying of possible ligature points, the removal of sharp objects and denying access to belts and other such objects which may be used to cause self-harm. Our observations of the environment and people throughout the day demonstrated the prevention of harm to people was a

significant feature of the service. Staff we spoke with had a good understanding of individual risks to people and knew how to manage these risks to keep people safe.
Each person had a personal emergency evacuation plan (PEEP) which showed the support people required if they needed to evacuate the home in the event of an emergency such as a fire. We saw these plans were present in people's rooms.

Where appropriate, people were able to come and go from the home as they pleased and their rights were promoted as they were not restricted in their movements and were able to freely leave the home. A "residents log" had been put in place to identify whether people were in or out of the building to ensure that in an emergency, such as a fire, staff knew who was in the building.

At the previous inspection, we found gaps in the recruitment process which meant the suitability of some staff had not been thoroughly checked. We found recruitment processes had improved and robust procedures were being followed which ensured staff were suitable to work in the service. We looked at three staff files and saw checks had been completed which included two written references and a criminal record check through the Disclosure and Barring Service (DBS). Interview records, proof of identity documentation, job descriptions and evidence of previous training was also present. We saw where issues had been identified during the recruitment process that these issues had been fully explored, risk assessed and reviewed as part of the decision making process about employment. This meant staff were suitably checked and should be safe to work with people who used the service.

People or staff raised no concerns about staffing levels within the home and said they were appropriate to ensure people received the required care and support. We observed care and support and found staff were visible and available to respond to people's needs for example promptly calming anxiety and providing social and emotional support. This led us to conclude there were sufficient staff deployed to ensure safe and effective care. Staffing levels were subject to regular review and were based on a dependency tool which looked at people's individual needs. Since the last inspection, the number of care workers had been increased to five in the morning, with four present in the afternoon. Additional staff were also on standby to provide 1-1 support to people, for example if they became distressed. During the inspection, we saw one person became distressed and standby staff were utilised effectively. We saw this was of benefit to the person who became calmer and engaged in activities with the staff member. Rotas' showed the required staffing levels were consistently met from day to day.

We saw the food standards agency had inspected the kitchen and had awarded them 5* for hygiene. This is the highest rating which can be awarded and meant food was being prepared and stored safely and hygienically. We found communal areas of the premises to be kept in a clean and hygienic state.

People told us that the home's environment was pleasant and a nice place to live. We looked round the home with one of the senior care staff. The home was generally well maintained, clean and there were no discernible odours. We saw signs on bathroom and toilet doors to help people identify these rooms and bedroom doors had people's names on. We looked at a sample of bedrooms and found some were personalised whereas others had few personal belongings displayed. We saw screening was provided in shared rooms to ensure people's privacy and dignity and call bells were accessible by people's beds. We found the carpet in the corridor on the first floor was torn, however the provider told us this had already been identified and they had arranged for a carpet fitter to visit the day after the inspection. We identified some minor issues which included a dirty bed side table, a loose headboard and a dirty sheet on one bed. We raised these with the provider and registered manager at the feedback session who assured us these matters would be addressed.

We found up-to-date safety certificates were in place for the passenger lift, as well as gas safety, legionella, portable appliance tests, fire alarm and protection equipment and electrical wiring installation.

At the last inspection we found that appropriate assessments were not being completed to ensure that people's bedrooms and the overall environment was safe and appropriate to their specific needs. At this inspection we saw records of room checks which were being carried out at least once daily and more frequently if a person was assessed as high risk. We saw staff had received training in how to complete these checks competently which helped given us assurance that people were safe. These checks included areas of risk of harm to people such as ligature points. We saw other environmental safety measures were in place such as restrictors to limit the window opening and radiator guards. Security checks were undertaken on the building each night to ensure it was appropriate, secure and helped keep people safe.

Requires Improvement

Is the service effective?

Our findings

People were complimentary about staff and said they thought staff were very good and met their needs. One person said, "I am very well cared for." We spoke with a visiting health professional who said, "The staff are always helpful and are responsive to any suggestions made."

Staff we spoke with told us they received a range of training which gave them the skills required to care for people with mental health needs. New staff were required to undertake a full induction to the service, its ways of working as well as completing mandatory training topics. New staff without a level three qualification in health and social care were also required to complete the care certificate. This ensured that new staff received a standardised induction in line with national standards.

Arrangements were in place to provide existing staff with regular training updates in subjects such as moving and handling, managing violence and aggression, mental health, safeguarding, fire and dementia. We saw a number of improvements had been made to training provision in recent months with a greater range of training provided. Although progress had been made, a number of staff were still awaiting training in fire, mental capacity, managing violence and aggression, and drug awareness. We saw a schedule of training was in place to provide this and other training over the coming months. This would ensure help ensure staff continued to developed enhanced skills and knowledge to help provide effective care. Staff we spoke with had a good knowledge of topics such as safeguarding and mental capacity act which demonstrated training in these areas had been effective.

Quizzes and competency checks were also undertaken to check staff knowledge. However we identified that medicines competency checks were not suitability robust as they had assessed staff were aware of what to do if a person refused their medicines. This was contrary to our findings.

Staff received periodic supervision and appraisal. We saw these were an opportunity to discuss topics such as using the computerised care recording system as well as safeguarding matters, and behaviours that challenge These supervisions focused on the development of staff and increasing their skill and knowledge and asking them about any ideas to further improve the effectiveness of the service.

Throughout our inspection we saw people who used the service were able to express their views and make decisions about their care and support. We saw staff seeking consent to help people with their needs. For example, people who were prescribed prn medicines were asked if they required the medicine not only at the regular medicine administration times but throughout the day.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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.

We saw four standard authorisations had been submitted to supervisory bodies for people who used the service. We saw conditions attached to authorisations had been translated into support plans and enacted. Of the remaining people receiving care we found no indications DoLS were required. The acting manager and support staff we spoke with were able to demonstrate an understanding of the Mental Capacity Act 2005 (MCA) and of the Deprivation of Liberty Safeguards (DoLS).

We spoke with one member of care staff about the use of restraint. They were able to describe de-escalation techniques to minimise the use of restraint. We saw detailed care plans for people who may for their own safety or the safety of others need to be physically restrained. Where restraint was assessed as required, we saw the minimum of intrusion was being used for the briefest periods of time. We saw one care plan where known behaviour patterns were recorded. Detailed information was recorded on how staff should respond to each known behaviour to reduce distress and anxiety. During observations of care, we saw staff managing behaviours that challenge well, talking to people in a re-assuring way, distracting them, setting up regular routines, keeping people active and making sure activities were interesting, helping people to relax and keep calm and avoiding situations that may trigger the symptoms.

We reviewed the care records of a person with a mental illness who had previously been detained in hospital under the Mental Health Act 1983. We saw at the time of admission to the service the person had been discharged from hospital on a Community Treatment Order (CTO). CTO's were introduced to the Mental Health Act 1983 by the Mental Health Act 2007. These orders allowed people to be discharged into a community setting whilst still being subject to mandatory conditions. We found the service was acting appropriately in managing this person's care and support.

People told us they enjoyed the food and said they were offered a choice. People had access to a good range of meals with a four week menu in place based on people's individual likes and preferences. At breakfast time people had the option of a cooked breakfast as well as toast and cereals. At lunchtime there were numerous options available, for example on the day of the inspection there were five meal choices. This included both western food and South Asian cuisine including meat and vegetarian options. In the evening time people had access to a choice of sandwiches and lighter options. The menu was on display in the dining area, with pictures of food used to aid understanding. However we noted only the western options were displayed with the South Asian options not on the menu. We asked the acting manager to ensure the full range of options available to people was listed.

We observed lunch in the dining room and saw people were offered a choice of meals when they sat down. We saw people were offered hot and cold drinks and those who were able could access these themselves from the drinks station. Staff were available and provided support to people where needed. There was a calm, relaxed atmosphere and one person put some music on to listen to while they were eating. People we spoke with told us they had enjoyed their meals.

At the previous inspection we had concerns that nutritional risks were not appropriately managed. At this inspection we found improvements had been made. Where people were at risk of poor nutrition, this was identified through risk screening and clear person centred plans of care put in place. Where people were losing weight or identified at risk, advice was sought from health professionals, food was fortified and increased monitoring of people's food intake and weight was undertaken. Food charts were subject to a

documented review to assess whether people had had enough to eat. This gave us assurance that the service was being appropriately diligent in monitoring the risk of malnutrition.

Information within the kitchen was present which informed kitchen staff of people's culinary needs for example who needed their food fortifying. Kitchen staff we spoke with were clear on people's individual needs and how to meet these for example knowing whose food was fortified and how this was achieved.

People's healthcare needs were assessed by the service and clear and person centred plans of care put in place. Care records we reviewed showed people had access to a range of NHS services and we saw the involvement of GPs, community psychiatric nurses and social workers. An optician was visiting and carrying out eye tests during our inspection. One person told us they were pleased they had seen the optician as they were arranging for them to have some new glasses. However we found the recording of GP visits needed to improve as on two occasions we were told a GP had been consulted about a person's health care needs yet we could find no record of these discussions.

Good

Is the service caring?

Our findings

People who used the service said staff were kind and friendly. One said, "[name of staff] is a good mate to me and always makes sure I am ok." People also praised the friendliness of the acting manager who they said was always visible and checked on people daily to see how they were feeling.

During observations of care we saw staff were caring and considerate in their interactions with people. For example we witnessed one staff member take the time to engage with a person over a long period of time about what was on the television and in assisting them to plan a holiday. We observed an inclusive atmosphere within the home with the staff team working well together and interacting with people in a positive way. We noted there to be a calm and settled atmosphere. This helped people who had identified problems with distress which could result in behaviours that challenge. Staff spoke quietly and gave encouragement for people to participate in conversations. We saw staff respected people's privacy. For example, we saw staff knocked on doors, announced who they were, asked if they could enter and waited for a response before going in.

Dignity and respect were monitored by the acting manager and provider on a regular basis. We saw an example where a concern had been noted by the management team and action was taken to investigate and resolve. This demonstrated the provider recognised the importance of ensuring people were treated with dignity and respect.

People had assigned key workers. These provided a named contact with whom people could discuss their care and support arrangements. People who used the service spoke a variety of languages. The service had made reasonable adjustments to ensure these people were regularly communicated with. This included assigning staff who spoke those languages to spend extended periods of time with these people and making use of computer technology

The service developed plans of care to promote people's independence. People were encouraged to leave the home unaccompanied to go about their daily lives. People were encouraged to make their own drinks at drink stations and clean their own rooms. Where people were deemed to have the capacity to make decisions for themselves, their choices and decisions were respected no matter how unwise they may have seemed.

Care records demonstrated that people had been involved in their creation and review and their individual likes, dislikes and preferences had been recorded. It was clear from reading the plans that they were written with terminology that the person who was being supported would use. Information was present on people's life histories to aid staff provide personalised care and support. Staff demonstrated a very good knowledge of people's needs, preferences and past clinical histories. This knowledge was used continually to foster an environment which was conducive to people's rehabilitation needs.

As well as computerised care plans being in place, staff had created visual care plans which were a concise and easy read summary of people's care and support needs. Staff told us these were useful for quick referral.

A copy was present within people's rooms and the staff room, this helped promote involvement of people who used the service.

The acting manager told us they practice an open door policy and went around each person daily to seek their views. People and staff confirmed this was the case and we observed it on the day of the inspection. There were also more formal mechanisms for people to air their views. This included regular resident meetings, care plan review and satisfaction surveys. We saw following issues being raised for example through the resident meeting, that actions had been responded to demonstrating the service listened to people. We saw evidence that relatives were able to visit the home whenever they liked.

Where appropriate, assessment of people's end of life wishes and needs was undertaken in conjunction with the person and/or their relatives. This helped ensure that people's needs would be met when they reached the end of their life.

Good

Is the service responsive?

Our findings

People we spoke with said care and support was appropriate and met their needs.

At the last inspection in December 2015 we found care plans did not always reflect people's needs and contained a lack of personalised information. At this inspection, we saw improvements had been made and care plans contained a full assessment of people's needs, were up-to-date and showed evidence of regular review. The acting manager told us they had involved people by sitting with them as they formulated their care plans to make sure these accurately reflected their preferences and needs. This was evident in the care records we reviewed which were person-centred and written in the first person. For example, we found detailed information about one person's hygiene needs which showed the person preferred female staff, could wash themselves with prompting from staff but needed staff to wash their back. The care plan also showed this person liked a specific number of food items as part of their meal and if these were not provided it caused the person distress. We saw these were provided at lunch time, which showed staff were aware of the care plan and following it. We saw visual care plans had been introduced which provided a pictorial and written summary of people's care needs. These were available to staff in people's bedrooms. This helped staff provide appropriate care.

We reviewed the care plans for people who had a history of misuse of alcohol and or illicit substances. We saw whilst there was no discrimination of these people the service demonstrated a responsibility and an intention to maintain an alcohol and illicit drug free environment for people. The provider's policies and people's care plans showed the service was discharging its legal obligation to prevent the possession or supply of illicit substances on premises for which they are responsible (Misuse of Drugs Act 1971). Where people displayed behaviours that challenge we saw clear care plans and staff guidance existed to minimise the risks to the person, other service users and staff.

We looked at another person's care plan who we were told was experiencing a decline in their mental health status. Care plans and records of care delivery demonstrated the service was responsive to their changing needs. We saw health and social care professionals had conducted reviews of the person's care needs and agreed with the provider the person's care needs would be better accommodated elsewhere. The care planning and delivery records showed staff had identified the decline in the person's health and acted in a timely way to source appropriate provision of care. Until a more appropriate location could be sourced we saw professional healthcare staff were visiting to support the care staff.

Where people had specific cultural or religious needs we saw these were assessed by the service and appropriate care planned and delivered. For example this included supporting people to access religious services and ensuring cultural appropriate food was provided. Our observations of care and questioning of staff lead us to conclude that staff had a good understanding of people's differing needs.

People and staff we spoke with told us improvements had been made to the provision of activities in recent months. A structured programme of activities was in place and we saw a new activities room had been created which had games set out on the tables to encourage people to participate. People we spoke with

told us there was a suitable provision of activities. One person showed us some jewellery they had made with staff and said they were very pleased with the support they had received to make it. We also saw trips out had been organised based on people's preferences. For example a recent trip had taken place to the Bradford industrial museum as well as to Blackpool and further trips were in the planning and consultation stage. Staff were able to give good examples of how they had positively engaged with people through the undertaking of activities that met people's interests? and preferences, improving relationships and reducing distress behaviours.

We found complaints were appropriately managed by the service. The complaints policy was displayed in the home and people told us they knew how to raise any concerns. The acting manager told us they operated an open door policy and said some of the people who used the service often came in and had a drink and a chat with them. We saw the acting manager was available to people and listened to what people had to say. The complaints log showed three complaints had been received since the last inspection. The records showed each complaint had been investigated and recorded any actions taken. Two of the complaints had not yet concluded, however the third complaint had been resolved and showed the response made to the complainant.

Requires Improvement

Is the service well-led?

Our findings

The provider had submitted the required notifications to the Commission including allegations of abuse. This helped ensure we could monitor events occurring within the service.

Since the last inspection an acting manager had been appointed who told us they were going to apply for the position of registered manager, replacing the current registered manager who would remain a member of the management team. We received positive feedback about the acting manager from both people who used the service and staff. One person told us "[acting manager] is really good, I have talked to her before, the home has got better since she came." A staff member told us "[acting manager] is lovely, really nice and friendly. She spends a lot of time with the residents."

We found the acting manager promoted an open and honest culture within the home. They were open with us about the progress made by the home, and areas where further development was still required. Staff we spoke with told us the acting manager had instilled a positive culture within the home. The acting manager practiced a "hands on" approach ensuring regular engagement with people who used the service on a daily basis to see how they were feeling and offer emotional support.

Since the last inspection, effective systems had been put in place to improve the service. We saw numerous improvements had been made to the quality of the service. This included provision of meaningful activities to people, better recruitment procedures, and more person-centred and relevant risk management and care planning. This had been delivered through increased management support and a structured service improvement plan.

Since the last inspection, we found improvements had been made to the way the service assessed and monitored the quality of the service. A more structured and robust approach to checks and audits now took place. This included visits by external organisations for example to conduct health and safety and medication audits. The acting manager and senior staff conducted a range of daily, weekly and monthly checks. This included care plan audits, infection control audits, safeguarding audits, recruitment audits and audits of daily documentation such as handover records and food charts. We found these audits were effective in identifying and rectifying issues through the use of action plans. Staffing levels were now regularly assessed and monitored through the introduction of a staffing dependency tool.

However whilst most quality systems had improved, we found medicine management audits and checks were not sufficiently robust. Despite daily, weekly and monthly checks being carried out, these had failed to ensure adequate was taken action following one person not regularly taking their evening medications for a period of several months. We also found medicine management competency assessments were not sufficiently robust as all staff had been assessed as competent in managing any refusals of medicines; however in practice this had not been the case.

A system was in place to log and investigate incidents and accidents which occurred within the service. There was evidence that appropriate actions were taken following incidents to prevent a re-occurrence.

Incidents and accidents were discussed at management meetings. At the time of the inspection, there was a lack of proper analysis of incidents and accidents to look for themes and trends. The acting manager assured us this system had recently been introduced and the results of the first set of formal analysis would be available at the end of the month.

Regular staff meetings took place. We saw these were an opportunity to discuss topics such as safeguarding and any quality issues. Management meetings were also held which discussed more strategic matters designed to further improve the service, and any escalation of concern/risk from staff meetings.

Systems were in place to seek and act on people's feedback to improve the service. Regular meetings took place with people and their relatives. We saw a range of items were discussed at these and the feedback used to make positive changes to the home and its environment. Periodic surveys were also undertaken to ask people's views on the service in a more formal and structured way.

We previously had concerns about whether the admissions process at the home was suitably robust to evaluate whether the service was able to meet the needs of new referrals. At this inspection we found a new admissions policy had been put in place underpinned by a more robust pre-assessment process. However at the time of the inspection there was a local authority embargo on new admissions to the service so were unable to evaluate whether this new approach was effective.

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 12 HSCA RA Regulations 2014 Safe care and treatment (1) (2g) Safe care and treatment was not provided as medicines were not managed in a safe and proper way.