Eagle Care Homes Limited

Eagle Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 6 July 2016 and was unannounced.

At the last inspection on 8 and 12 February 2016 we rated the service as 'Inadequate' and in 'Special Measures'. We identified seven regulatory breaches which related to safeguarding, staffing, consent, dignity and respect, nutrition, person-centred care, safe care and treatment including medicines and good governance. Following the inspection we took enforcement action. The commissioners at the Local Authority and Clinical Commissioning Group (CCG) were made aware of our concerns and placements at the home were suspended. Following the inspection the provider sent us an action plan which showed how the breaches would be addressed. This inspection was to check improvements had been made and to review the ratings.

Eagle Care Home provides accommodation and personal care for up to 33 older people, some of who are living with dementia. Accommodation is provided over two floors with communal areas, including three lounges and a dining room, on the ground floor. There were 23 people using the service when we visited.

The home has a registered manager who has been in post for over two years and was present at the inspection. 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.

Although we found some improvements had been made to the care people received in areas such as safeguarding, activities and the cleanliness of the environment, we found a number of regulatory breaches remained.

We found there were not always enough staff on duty to keep people safe and meet their needs. Although the provider told us they had worked out they were overstaffed by nine hours, they were not able to show us how these calculations had been made. We found there were times during the inspection when staff were not available to meet people's needs. We found shortfalls in the recruitment procedures had not been identified or resolved by the provider.

Risks to people were not managed well. For example, we found some staff did not know the correct procedures to follow in the event of a fire. Safeguarding had improved as staff had received training and knew the reporting procedures. We saw incidents were recognised, dealt with and reported appropriately.

Medicines management was not always safe which meant people were at risk of not receiving their medicines when they needed them. A medicine error occurred on the day of the inspection, which was recognised promptly and the correct action taken. However, the correct administration procedures had not been followed and if they had the error would not have happened.

We found the home was clean and improvements had been made to the environment such as new flooring, better lighting and a new call bell system.

We saw the provision of food and drinks for people who got up early had improved and saw people were offered early breakfasts. However, we still had concerns about how people's nutritional needs were being met as records showed some people were often eating and drinking very little and had lost weight. We found food and fluid charts were not monitored or reviewed to make sure people were receiving sufficient to eat and drink.

We found staff had received training since the last inspection in areas such as safeguarding, first aid and basic life support. However, gaps remained and the provider was unable to provide us with up to date information about the training staff had received. Systems were in place to ensure staff received regular supervision and appraisals.

The registered manager was aware of the legislative requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Six people had DoLS authorisations, although we found conditions applied to the authorisations had not always been implemented. Staff had not received training in MCA and DoLS although we were told this was planned.

People had access to healthcare services although we found staff were not always prompt in contacting healthcare professionals when people's needs changed. Care was not planned or delivered to meet people's individual needs.

We observed some kind, caring and sensitive interactions between staff and people who used the service. However, we found examples which showed a lack of respect for people and compromised their dignity. The provision of activities had improved. The home employed and activities co-ordinator and we saw there were a variety of activities and events provided for people.

People and staff told us improvements had been made since the last inspection and we found the home was more organised. However, quality assurance systems were not fully embedded or robust which is evident from the continued breaches we found at this inspection.

We found continued shortfalls in the care and service provided to people. We identified six breaches in regulations – regulation 18 (staffing), regulation 12 (safe care and treatment), regulation 14 (nutrition), regulation 10 (dignity and respect), regulation 9 (person-centred care) and regulation 17 (good governance). The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service remains in 'Special measures'.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were insufficient care staff deployed to ensure people's needs were met and they were kept safe. Shortfalls in the recruitment processes had not been identified or resolved to ensure staff were suitable to work in the care service.

Medicines management was not always safe and effective, which meant people did not always receive their medicines as prescribed.

Risks to people's health, safety and welfare were not properly assessed and mitigated. Improvements had been made in safeguarding as staff had a good understanding and incidents were recognised and reported.

The premises were clean and infection control practices had improved.

Is the service effective?

Inadequate

The service was not effective.

People's weight and nutritional needs were not monitored effectively which meant people were at risk of not receiving enough to eat or drink.

Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) legislation was not always being followed.

Staff had received some training updates since the last inspection, however gaps in training remained.

People had access to healthcare services, however staff were not always prompt in contacting healthcare services when people's needs changed.

Is the service caring?

Requires Improvement

The service was not always caring.

We saw some caring and kind interactions between people and staff. However, we observed practices which showed a lack of respect for people and compromised their dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care was not planned or delivered to meet people's individual needs.

Activities had improved and we saw people enjoyed participating in a variety of different events

Complaints were not reviewed at this inspection.

Is the service well-led?

Inadequate

The service was not well led.

Although some improvements had been made since the last inspection, regulatory breaches remained which placed people at risk of receiving unsafe care and treatment.

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

This inspection took place on 6 July 2016. The inspection was carried out by three inspectors and was unannounced. We started the inspection at 6.40am so we could meet the night staff.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioners and the safeguarding team.

We usually send the provider a Provider Information Return (PIR) before the inspection. 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. We did not send a PIR on this occasion.

We spoke with two people who were using the service, four relatives, four senior care staff, six care staff, the cook, the maintenance person, the registered manager and one of the company's directors. We also spoke with three healthcare professionals.

We looked at seven people's care records, three staff files, medicine records and the training matrix as well as records relating to the management of the service. We looked round the building and saw people's bedrooms, bathrooms and communal areas.

Inadequate

Is the service safe?

Our findings

At our previous inspections in February 2015 and February 2016 we found systems and processes in place to manage medicines were not always safe or effective. At this inspection concerns remained.

The staff member who was administering morning medicines told us they gave time specific medicines, which had to be given 30 minutes before food, to people first when they started the medicine round at 8am. We saw them give this medicine to a person who we had seen having breakfast earlier. The staff member had not checked if the person had had breakfast and we discussed this with the registered manager and the staff member. The registered manager was carrying out a medicines competency assessment on the staff member while they were administering the medicines but had not observed this medicine being given.

At 10.15am the company director informed us a medicine error had occurred. They told us the staff member carrying out the morning medicine round had administered a controlled drug to a person which was prescribed to be given at night. The company director told us they had witnessed the staff member giving this medicine to the person. The company director acted promptly and appropriately following the incident as they contacted the person's GP, notified the person's relatives and ensured the person was monitored by staff. The staff member was removed from administering the morning medicines which the registered manager took over. However, when we asked the company director to explain what had happened it was clear the correct procedures for administering a controlled drug had not been followed by either the staff member or the company director.

We reviewed the medicine administration records (MAR) at 12.05pm. We found 13 people's morning medicines had not been signed for on the MAR. We discussed this with the registered manager and checked with them to see if the medicines had been given. Our checks showed 11 people had received their medicines but the MAR had not been signed and for four of these people the medicines had been given by the registered manager and not signed. The registered manager signed the MAR when we identified these gaps.

Our checks showed two of the 13 people had not received their morning medicines. The registered manager told us one person had not got up until 11am and they would give them their medicines later. The registered manager was not able to explain why the other person had not received their medicines.

We checked the stock levels of three people's medicines with the registered manager and found discrepancies in all three. In two cases there were more tablets left than had been signed for on the MAR which suggested the medicine had been given but not signed for on the MAR. The other medicine was an antibiotic suspension and the amount left was greater than it should have been according to the signed entries on the MAR, which suggested the medicine had not been given as signed on the MAR.

We looked at the home's medicine policy which said team leaders were responsible for administering medicines and were not permitted to do so until they had received training in medicine management, had completed a competency for medicines administration practical test and had been assessed as competent

by the registered manager. We looked at the medication competency checks and found these were not fully completed. Two of the assessments we looked at recorded the name of the staff member, although no details concerning an assessment were filled out. Two other assessments had been completed. However, the assessor had not identified whether the staff member was competent or otherwise and the assessor's signature and date were not filled in. This meant the registered provider did not have effective systems in place to assess whether staff were competent in administering medicines.

There were no team leaders on the night shift. We spoke with the staff member on nights who told us they were in charge of the night shift. They told us they had received medicine training under the previous manager and had had some training from Boots 'a long time ago'. They said further training was planned. We saw this staff member had keys for medicines although they told us they only gave painkillers if needed overnight, which were kept in a separate locked cupboard next to the medicine trolley. We discussed this with the company director and registered manager. The company director told us they had already identified that this was an area that needed to be addressed. We concluded there were not safe systems in place to manage medicines and therefore the provider remained in breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At both of our previous inspections we found there were not always sufficient staff deployed to meet people's needs and we had the same concerns at this inspection.

During our inspection we asked staff how many people needed two staff to assist them with moving and handling transfers. One staff member told us this applied to 10 people, whilst the registered manager told us this number was five. The registered manager had recently adopted a new staff dependency tool which they had used to identify the levels of assistance each person living in the home needed. We saw these were not signed or dated. The company director told us the service was over staffed by nine hours of care time. However, the overall calculation used to identify the number of staff hours needed for the level of dependency had not been completed. This meant we were unable to see how the registered provider had identified the number of staff required on each shift.

We asked staff if they thought there were enough staff. One staff member said, "We could do with one extra when the district nurses are in on a Monday and Thursday." Another staff member told us they were satisfied with staffing levels. A further staff member said, "As long as people don't phone in sick, I think we've got enough."

During the morning of our inspection we observed a period of over 20 minutes when no staff members entered one of the lounges. We saw one care worker had to break off assisting one person with their lunch so they could assist another care worker to transfer someone into their wheelchair because there were no other staff available.

We observed lunch and found some people had to wait up to 20 minutes before their starter was served. We saw one person given soup had fallen asleep. Later, a staff member woke them gently to ask if they wanted chicken casserole which they said they would like. When their main course was served, the staff member asked the person whether they still wanted their soup. The person responded, "Oh, is it here?" They then had the soup and the staff member later warmed up their main course. We found people ate minimal amounts of food and saw staff were very busy as they supported people in and out of the dining area and served meals to people in their rooms and lounges. This meant people did not always receive sufficient support and encouragement to eat their meals as staff did not have time to do this.

The company director told us the usual staffing levels were a team leader and three care workers from 8am

until 10pm and three care workers on the night shift from 10pm until 8am. There was also a domestic and cook on duty each day. The registered manager hours were supernumerary and there was an activity organiser who worked from 10am until 5pm Monday to Friday.

We looked at the duty rotas from 6 June to 3 July 2016 and found during that time occupancy levels had varied from 22 to 24 people using the service. We found on seven nights there were only two care staff on duty. We considered these staffing levels were unsafe and insufficient to meet people's needs. This was a breach of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment processes followed for three staff members and found they were not always safe. Two staff members had been recruited with certificates from the Disclosure and Barring Service (DBS) dated October 2014. The registered provider's recruitment policy stated, 'Once all candidates have been interviewed, the successful candidates are contacted and asked to agree to a fully enhanced DBS. The fee for the DBS is collected on this day too. The candidate undergoes the DBS, a check against the barred list and is verified that they a member of an appropriate professional body (if applicable)'. This meant the registered provider was not following their own recruitment policy. Staff did not always indicate on their application form whether they had any cautions or convictions to declare. We saw evidence including application forms, health questionnaires and robust interview notes. However, one staff member's file did not contain evidence of their identity being checked. These shortfalls had not been identified or resolved by the provider's governance systems. This was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we found risks to people were not managed safely or appropriately and had the same concerns at this inspection. When we arrived at 6:40am we asked the care worker who was the shift leader on night duty, how many people were living at the home. They told us there were 22. Another night care worker told us there were 24 or 25 people living there. When we checked with the registered manager there were 23 people in residence. One staff member told us they had received no fire training although they said they thought some was planned. They told us they had not taken part in a fire drill and would not know what the fire alarm sounded like.

We asked staff about the procedure they would follow in the event of a fire. One staff member told us they would identify the location of the fire and assist people who were in communal areas to evacuate the building, whilst people in their rooms would remain there as the fire doors would protect them. Another staff member told us they would try and move people away from the location of the fire to another part of the building. A further staff member told us they would dial 999, wait for the fire brigade to come and then start getting people out. This was not in line with the service's evacuation plan. The fire evacuation procedure on display stated staff should commence a horizontal evacuation of the building. We found staff were unsure about the location of the evacuation point outside the building. A personal emergency evacuation plan (PEEP) was available for staff to refer to in the event of a fire. We were told by a staff member that all fire training was being updated.

We asked the registered manager for the fire risk assessment and they showed us the 'fire risk assessment checklist' but not the actual fire risk assessment. When we looked at the care records we saw people had personal emergency evacuation plans (PEEPS) in place. We asked the registered manager if copies of these were kept in a separate file, so that in an emergency this information could be found quickly. They told us this information was only available in the care files.

The registered manager told us the fire authority had been in the last few months. We contacted the fire authority and they confirmed they had visited and carried out a re-audit in May 2016 and found the service

had complied with their requirements. We discussed the issues we had found during the inspection and referred these back to them.

We saw in one person's bedroom they had safety sides on their bed which the registered manager confirmed were used when they were in bed and a crash mat at the side of the bed. We saw in the daily records on 17June 2016 staff had written, '[Name] has been closely monitored due to climbing over bedrails.' We saw an accident form had been completed on the same day which stated the person had been found on the bedroom floor 'resting against the chair, red mark to left side of ear, needs referring to OT (occupational therapy) for a crash mat.' On the risk assessment dated 21 June 2016 we saw recorded, 'bed rails in use, sometimes attempts to climb over bed rails.' When we asked the company director about the accident they told us the person had not got over the safety sides and thought they had moved themselves down the bed and managed to get out of the bed. We asked to see the 'workings out' about how the decision had been made to leave the safety sides in place. There was no documentary evidence to show how this decision had been made to ensure this person's continued safety. We concluded there were not safe systems in place to manage risks to people and therefore the provider remained in breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw improvements to the environment had been made since our last visit in February 2016. New flooring had been fitted in the patio lounge and dining room, the patio area had been cleaned and planters had been filled with flowers, making a pleasant area for people to use in fine weather. Additional sounders had been fitted so the emergency call bells could be heard throughout the building and staff told us they also had 'walkie talkies' so they could contact each other when they required a second carer to assist. The 'push down' taps had also been replaced with ones which were easier for people to use. There was a system in place for staff to be able to record any concerns regarding maintenance. This information was recorded by staff in a central log which the handy person used to identify and carry out repairs.

The home was clean, although there was an underlying unpleasant odour in the 'cricket' lounge. We saw staff had access to disposable gloves and aprons, but did note some staff were wearing rings with stones in, which was contrary to the home's policy. We saw two staff had been identified as infection control 'champions'. Training records we looked at showed these staff members had been booked on to a course in July 2016 which they were expected to tell other staff about afterwards.

We found improvements had been made in relation to safeguarding. We saw safeguarding incidents were well recorded and showed the action that had been taken to keep people safe. The records showed referrals had been made to the Local Authority safeguarding team and notified to the Care Quality Commission. The registered manager told us most of the staff had done safeguarding training which had been delivered by the local authority safeguarding team. They said all of the team leaders had been trained on how to make safeguarding alerts and this was confirmed when we spoke to team leaders. We saw a copy of the staff whistleblowing policy was on display. 'Whistleblowing' is when a worker reports suspected wrongdoing at work. Staff we spoke with were aware of the whistleblowing procedures and felt confident appropriate action would be taken if they identified and reported unsafe staff practice.

Inadequate

Is the service effective?

Our findings

At both our previous inspections we found people's nutritional needs were not being met. At this inspection although some improvements had been made we identified similar concerns.

Relatives we spoke with said, "I don't think the food's too bad" and "The variety is good." The notes from the residents meetings in May and June 2016 both said people had expressed their satisfaction with the meals and snacks available.

We found breakfast times were more flexible and saw people who were up early were offered a hot drink of tea and choice of two cereals or toast. One staff member showed us a chart where night staff recorded who had received breakfast and a drink so they could make sure no one had been missed.

We saw a list in the kitchen showed which people needed fortified meals and prescribed supplements. However, we saw one person, whose care records showed they required a fortified diet was not on the list. The cook told us the mashed potato was always fortified using double cream and milk pudding contained full fat milk. However, at lunchtime we saw the portion sizes were small. There were four or five small piece of chicken in each portion of chicken casserole and one small scoop of mashed potato. One staff member told us people were given snacks between recognised meal times. They said during the day people could have biscuits, cheese and crackers, buns, chocolates, and choc-ices. At supper time people could have toast, sandwiches, crumpets, cakes, current teacakes, crackers and jam and crackers with cheese. However, during the inspection we did not see these choices being offered and the food charts we reviewed did not show people had received this variety of snacks. Mid-morning biscuits were offered with tea and in the afternoon there were cakes.

We saw jugs of juice and a stack of plastic tumblers on a table in the cricket and patio lounges, however we found people were not provided with these drinks. We saw one person in the cricket lounge helped themselves to a drink and another person in the patio lounge had a drink next to them. However, staff did not offer anyone else a drink and the jugs and tumblers remained on the tables throughout the inspection.

Systems had been put in place to monitor everyone's daily food and fluid intake. The registered manager told us they checked the food and fluid charts and assessed the adequacy of people's dietary and fluid intake. However, we found people's nutritional needs were not being met. For example, one person's care records showed they had lost 6.7kgs between December 2015 and June 2016. The malnutrition universal screening tool (MUST) since December 2015 assessed the person as at low risk of malnutrition, yet another nutritional risk assessment assessed them as high risk. Staff were recording the food and fluid intake, but there was no guidance for staff about how much fluid the person needed to drink every day. The records showed their fluid intake over a nine day period ranged from 200mls to 1160mls. We calculated they should have been having 1680mls of fluid every day based on 30mls of fluid per kilogram of body weight (Water for Health Hydration Best Practice Toolkit for Hospitals and Healthcare). We asked the registered manager how much fluid they thought the person should be having on a daily basis and they told us between 1000mls and 1500mls. In the care plan we saw a fluid input assessment, which had last been reviewed on 26 June 2016

and stated 'Offer water between drinks to reduce the risk of dehydration.' This did not happen between the drinks which we saw this person was given at 7:10am, 11:20am and 1:10pm.

We looked at this person's food charts from 27 June to 5 July 2016 and saw they had eaten porridge eight times for supper and cake on one occasion. We asked staff about this and they told us this was because the person was on a soft diet and could not eat teacakes or toast.

On the day of the inspection we arrived at 6:40 am and saw this person in the lounge. Their mouth was dry, their tongue was coated and they had food matter around their mouth and chin. At 7:10am a care worker assisted them with cereal and a drink. They told us this person required full assistance from staff and needed a soft diet and their fluids thickened. Mid-morning drinks were served with biscuits, yet this person was not provided with any snack. At lunchtime a care worker brought this person a bowl of thickened tomato soup and liquidised chicken casserole, potato and vegetables on an uncovered plate. The cook told us it was 'packet' soup. We asked if it had been fortified and they told us it had not. This meant the opportunity to provide additional fortification to this person's meal had been missed. The main course was followed by banana mousse and cream and a drink. The care worker told the person what the lunch was and provided assistance with patience and kindness, although by the time the soup was finished the main meal would not have been hot anymore.

Another person's care records showed they had lost almost 2kgs in a month, yet the MUST score had not been updated and showed the person to be at low risk of malnutrition. Although another nutritional risk assessment identified in April 2016 that there was 'cause for concern'. Their care plan showed they had a poor appetite, declined main meals but liked sweet foods and to encourage high calorie snacks and offer extra portions. The care plan stated to 'push fluids' but there was no guidance for staff about how much fluid the person should drink each day.

We reviewed the food and fluid charts for this person from 27 June 2016 to the day of the inspection and they showed very little intake. For example, on the three days leading up to the inspection the person's total daily food intake was on 3 July two slices of toast and two thirds of a piece of gateau; on 4 July a bowl of porridge and a bowl of custard and on 5 July four mouthfuls of custard and half a bowl of porridge. This person's fluid intake over the nine days from 27 June 2016 ranged from a daily total of 520mls to a maximum of 1180mls.

On the day of the inspection we saw this person had very little food intake. In the morning they were asleep at the dining table and we saw the bowl of porridge, mug of tea and nutritional supplement were taken away by a staff member who told us the person had not taken them. Mid-morning we saw a mug of tea and two biscuits were placed in front of the person who was asleep in the chair. These were still there over an hour and a half later and had not been touched by the person who was still asleep. At 1.15pm we saw the person was still asleep in the chair while people were in the dining room having lunch. At 2pm we checked the food and fluid chart for this person and nothing had been recorded. We asked the team leader what this person had had for lunch and they said they had declined lunch but would be offered something later.

Another person's weight records showed they had lost almost 4kgs in a month. Again, the MUST score had not been updated and showed the person to be at low risk of malnutrition. Although another nutritional risk assessment identified in April 2016 that there was 'cause for concern'. Their care plan showed their appetite varied. The food and fluid charts from 27 June to the day of the inspection showed a poor intake on some days. For example, 28 June 2016 the daily intake comprised of three quarters of a bowl of soup, three mouthfuls of dinner and two biscuits. On 1 July 2016 the daily intake was a sandwich and fruit for tea and a sandwich for supper. Daily fluid intake from 27 June varied from a maximum of 1260mls to a minimum of

500mls. We concluded people's nutritional and hydration needs were not being met and therefore the provider remained in breach of the Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found there were gaps in staff training and refresher training was overdue. At this inspection we found some training had taken place, however we could not determine if staff had received all the training they required as records were not up to date.

Records we reviewed showed eight staff had attended a safeguarding awareness course in June 2016, 12 staff had attended a first aid course and basic life support in May 2016. The company director and staff told us a new e-learning training programme had been introduced which staff were expected to have completed by September 2016. The training records we looked at showed there were a number of training gaps. We discussed this with the company director who told us the training matrix needed to be updated to reflect recent training staff had completed. The training matrix we were shown was not dated and did not contain dates when staff had completed training or when their certificates expired. The company director told us they had planned to update the matrix on the day of our inspection. They also said there were two versions of the training matrix. We asked for copies of these, but they were not provided. We requested that the training matrix was sent to us following the inspection, however this has not been received. We concluded therefore the provider remained in breach of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's supervision policy stated staff should receive three supervision sessions a year. We looked at the supervision records and found all staff had received recent supervision sessions from May 2016 onwards, although prior to this date there was limited evidence of supervisions taking place. Supervision records varied in terms of the level of detail recorded which meant these sessions may not have always been effective. We found one example of a staff appraisal which took place in January 2016. The provider's policy did not indicate how often appraisals should take place.

As part of their induction, staff were required to complete three days shadowing and also completed training in, for example, moving and handling and fire safety. However, one staff member we spoke with who had been employed at the home for five months told us they had not received any fire training.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). DoLS requires care homes to make applications to the local authority where they suspect they are depriving people of their liberty.

The registered manager told us six people had a DoLS authorisation in place and ten DoLS applications had been made. We asked one staff member who had a DoLS in place and they told us they knew one person had but were not sure about anyone else. Another staff member could not tell us who had a DoLS authorisation in place but showed us where the information was kept. The training records we saw showed staff had not received training in MCA and DoLS although this was planned.

We asked the registered manager if anyone had their medicines administered covertly. They told us no one was but if this was necessary they would involve the GP, pharmacist and family to make sure this decision

was made in the person's best interest.

We saw the DoLS for one person dated 8 April 2016 had two conditions. One of these was to review and reassess the falls risk and record recent falls within the falls history. When we checked this person's care records we found the last fall recorded in the falls history was dated 1 July 2014. We asked the registered manager about this and they told us this person had not fallen since then. However, accident records showed the person had fallen in the dining room on 14 March 2016. This meant the registered manager had not complied with the condition on the DoLS.

Relatives we spoke with were satisfied people received appropriate support from health professionals. We saw the home arranged for a chiropodist to visit every eight to ten weeks. Care records we reviewed showed visits from community nurses, GPs, opticians and chiropodists. However, we were found that changes in people's conditions were not always identified or brought to the attention of health care professionals. For example, one person's records showed they had lost weight and had had a poor nutritional intake since returning from hospital. This was also confirmed by our observations of the person who was very sleepy and had eaten and drunk nothing by mid-afternoon on the day of our inspection. There was nothing in the care records to show the person's GP or any other healthcare professional had been made aware of these issues. We spoke with the community nurse who was visiting this person on the day of our inspection and asked them if they had been informed of these matters and they said they had not.

We saw another person had a dry mouth and their tongue had a white coating. We raised our concerns with the registered manager who told us the person's mouth was always dry as the person's tongue was out all of the time. At the end of the inspection the registered provider said the person had been treated for a fungal infection in the past and was being treated currently. Following the inspection we contacted the health care professional who told us they had been asked to see this person during our inspection and had prescribed treatment. They said previous treatment which had been prescribed on 13 June 2016 had not been effective. We were concerned that had we not raised our concerns with the registered manager, the person may not have received the treatment they required. This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

We received some positive comments from people and their relatives about the staff. One person told us, "It's a right nice place this. They love me a lot." Another person said, "It took me a while to settle in but I'm okay now. Staff are very nice and look after me." A further person said, "It's all right here. Staff are nice, most of them." As a staff member walked past one person they said to us, "She's a good friend to me and looks after me." One relative who was concerned about their family member becoming less active told us, "They do get her up every day. I think that they're okay. They've got a really hard job." Another relative said, "We're generally happy. The staff seem nice."

One compliment on display in the home read, 'Thank you for looking after my father [name of person] of the last four years. Your care for him has been second to none'.

One relative we spoke with told us they were made to feel welcome when they visited the home, but said they had been asked not to visit at lunchtime unless they were prepared to assist people with their meals.

We saw positive interactions between staff members and people who lived in the home. Staff demonstrated they were kind and caring in their approach and were seen working at eye level with the people they were interacting with.

We saw staff gave people choices and asked for their permission before assisting them. This was particularly noticeable at breakfast when we saw staff offered people alternatives when they noticed people had not eaten much. One staff member asked a person, "[Name of person] are you going to try some toast love?" We saw another staff member assisted someone to have their breakfast in a way which was supportive and unhurried. One staff member who wanted to help someone with a protective apron asked them, "Can I put this on whilst you have your breakfast?"

During lunch we saw staff wore protective aprons and offered these to some people in the dining area. Tables were nicely set with tablecloths, place mats and flowers. We saw people were given choice of blackcurrant or orange juice. One relative told us, "They always set the tables out nicely with tablecloths and flowers."

Staff we spoke with were able to tell us how they would protect people's privacy and dignity. One staff member told us they would close the curtains when providing personal care and use towels to maintain people's dignity. They told us, "You don't want to leave them not covered up." Relatives we spoke with were satisfied their family members were treated with dignity and respect. However, we saw one staff member entered people's bedrooms without knocking.

We saw the majority of people looked well groomed, wore clean clothing and had their hair brushed. We saw some ladies wore jewellery and others had their nails painted. However, we found the same attention had not been paid to other people's appearance. For example, we saw two ladies had not had their hair brushed. We saw one person had been dressed with trousers which had a broken zip. We heard another

person who had been brought into the dining room say they hadn't had a shave. When we spoke with the person they confirmed this and said they would like one. The registered manager overheard and told us, "This has been organised", which we told the person. We saw the person an hour later in the lounge and they still hadn't had a shave. Their relatives said when they visited the person often had not had a shave.

We saw staff assisted one person with a drink. The first time they put an apron on the person to protect their clothing but the second time they did not. The tea was spilt on the person's top which was not changed. On both occasions they left the person with drink around their mouth as there were no tissues or wipes to hand and they had to go and find some. We saw another person having difficulty taking a drink from their cup. Staff had given them a straw which had fallen out of the cup. As the person tried to take a drink from the cup, we saw some liquid pouring into their lap. We overheard a relative later in the day asking, "What worries me is when we aren't here, who will hold the glass?" We saw tea was the only hot drink offered at mealtimes and in the morning and afternoon. When we asked a staff member if there was coffee available they told us it was but said, "It's very rare people want coffee", although when we arrived one person we spoke with told us they preferred coffee.

When we inspected the service in February 2016 we found people were being showered in water temperatures between 34 and 35^{0} C. On this visit we saw on the bath records this was still the case. For example, one person's bathing records show the temperature of the water was 34^{0}C on 12 and 19 April 2016 and 35^{0}C on 30 April 2016. Another person's bathing records show between 30 May 2016 and 5 July 2016 they were bathed or showered in water with a temperature of 34^{0}C. Given people's body temperature is around 37^{0} C we concluded the water was not hot enough for people to use in comfort.

We found aids to promote people's independence and to help people living with dementia make choices still required improvement. For example, although there was a clock showing the right date and time in the dining room, the clock in the foyer showed the date as Friday 20 May. Similarly, although there was a written menu displayed in the dining room which showed the meals for the day there were no pictures of meals to help people living with dementia make a choice. After breakfast we heard the cook asking people if they wanted a jacket potato with tuna or chicken casserole for their lunch. One person asked, "What is tuna?" The cook said it was fish but the person still did not understand so the cook said, "Shall I just choose something you will like."

This was a breach of the Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we found care and support was not planned or delivered in a person-centred way to meet people's individual needs and preferences.

The registered manager told us they were putting new care documentation in place for everyone and said this had been put in place for four to five people. Care records we reviewed showed some improvements as we found sections of them provided more detail about the care and support people needed. However, we found there was contradictory information and care plans and risk assessments had not always been updated when people's needs had changed. For example, two people had two different nutritional assessments which gave different risk levels, one showing low risk, the other stating there was 'cause for concern'. One person's records showed their mobility had declined and they now needed two staff to assist instead of one, yet their care plan and risk assessments still showed only one staff member was needed. This person's care plan showed they wore glasses and wore hearing aids in both ears. On the day of the inspection we saw they did not have any of these aids in place. The nutritional care record for another person who was on a soft diet stated they could manage finger foods, yet the registered manager confirmed they could no longer manager finger foods.

We looked at the care plan of a person who had a dry mouth and coated tongue. We saw their oral assessment was last reviewed on 26 June 2015 and identified no risk. However, using this tool we calculated with a dry mouth and a coated tongue the risk should have been high. We saw this person needed support from staff to meet their continence needs. The care plan stated they should be assisted to the toilet every two to three hours during the day, at midnight and 4am. We saw this person was up and sitting in the lounge at 6:45am and was not assisted to the toilet until the early afternoon when they went for a rest in bed. We asked the registered manager about this and they told us this person was only allocated three incontinence pads per day so could not be changed as frequently as the care plan indicated.

We saw a number of people were using pressure relieving equipment to reduce the risk of tissue damage. When we looked in some of the bedrooms we asked the registered manager if they knew what settings the mattresses needed to be on. They told us the district nurses did this and if the setting changed the mattress alarm would go off. The mattresses are set according to people's weights and only set off an alarm if they malfunction. If the wrong setting is used the therapeutic value of the mattress would be affected.

The company director told us an activities co-ordinator had been appointed since the last inspection, although they were on annual leave when we visited. This staff member worked from 10am until 5pm from Monday to Friday. The registered manager told us staff were expected to provide stimulation for people whilst the activities coordinator was absent.

During the morning we saw people in the patio lounge enjoyed a reminiscence session with three people who were part of a Community Group from Huddersfield. They told us they visited every Wednesday morning and this was their sixth session at the home. We saw they used different memory aids to promote discussions with people and we saw people responded well smiling and chatting. In the afternoon we saw

staff were trying to engage some people in dancing to music. One relative we spoke with told us they had noticed more activities taking place in recent weeks.

Information about weekly activities was displayed and included events such as armchair exercises, quizzes, arts and crafts and sing-a-longs. One person's care records showed they had enjoyed a game of skittles, had taken part in a sing-a-long and gone out for a walk. A weekly shopping trolley was available for people to purchase sweets and toiletries. We also saw a trip out to Harry Ramsden's was planned for July 2016. The minutes from the residents meeting in May 2016 noted people had enjoyed a visit from a singer. We saw they had visited again in June and were scheduled to return in July. A Church service in the home was scheduled for the end of July 2016.

We did not review complaints at this inspection.

Inadequate

Is the service well-led?

Our findings

It was evident from our observations and feedback from people, relatives and staff that improvements had been made since the last inspection. However, we found a number of breaches remained which demonstrated shortfalls in the quality of care people received.

The breaches we identified in the other sections of this report showed that the quality assurance systems in place were not effective as issues we found had not been addressed. Medicines were not managed safely as staff were not following the home's procedures and staff competencies had not been determined. Shortfalls in the recruitment processes had not been identified or resolved. Although people's dependencies had been assessed, there was no evidence to show how this information had been used to determine safe staffing levels. We found there were times when staff were not available to provide the support people needed, such as lunch time.

We looked at accident and incident reports and found these lacked detail as it was not always clear what had happened. For example, an accident report for one person stated they had been getting off the bed, lost their balance, fell backwards and landed on the floor. As a result of this fall the person had sustained a fractured hip. The registered provider had notified us about this incident as they had made a safeguarding referral. However, the account in the notification differed from the accident report as it showed a staff member had been present when the accident occurred. It also showed there had been a two hour delay in calling an ambulance. We asked the company director about this and if there had been any investigation into the incident. They told us they had spoken to the staff member and asked them to write a statement. We saw the statement which was very brief. The company director was unable to provide us with any further information to show that this incident had been investigated to ensure appropriate and timely actions had been taken in response to this person's serious injury. Following the inspection we made a safeguarding alert to the Local Authority safeguarding team.

We asked the registered manager for the accident and incidents analysis they carried out. We saw this consisted of a monthly audit sheet for each person which listed any accidents they had sustained over the month. There was no analysis of the information to identify trends or themes or look at 'lessons learnt' to prevent recurrences, which was the same situation we had found at our previous inspection.

The registered manager showed us monthly weight audits they had carried out, which was an improvement as there had been no weight audits carried out at the previous inspection. However, we found the analysis was limited. At the feedback sessions we asked the registered manager and company director about people who had lost weight and whose records showed their nutritional intake was poor. They were unable to provide us with assurances that people's nutritional needs were being met. The company director suggested the weighing scales were wrong and told the registered manager to go and weigh the people we had raised concerns about. We requested this was not done at this time as people were having their tea.

We looked at the policies and procedures file and saw most had been produced in 2012. They had been signed as having been reviewed in August 2013 and August 2014 with 'no change' recorded.

The registered manager told us they did not carry out staff surveys. We looked at the results of the June 2016 'resident' survey which were on display. We saw nine people had provided feedback on quality, the manager, the environment, the meals, care staff and the activities. Overall, people indicated they were satisfied with the service they received, although we noted the only options they could select were 'good/excellent', 'fair' and 'satisfied/not sure' which meant there was no option to select if a person was dissatisfied. The information on display stated; 'Thank you to all nine people that took part, we seek to make further improvements from your comments'. We asked the registered provider and registered manager what action they had taken in response to people who had not expressed their satisfaction, particularly regarding activities. They told us they would follow this up. One relative told us they had been asked to complete a survey, but were concerned they needed to hand this directly back to the registered manager. Another relative said, "It was difficult to be as candid as we would have liked."

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

The home had a registered manager who was present on the day of the inspection, as was the company director. The company director told us about some of the improvements they had made and said they thought they were 90% there. They told us two of the people using the service needed nursing care but as there were no nursing beds available they had to stay at Eagle Care Home.

We asked staff about the support they received from the registered manager and the company director. One staff member said, "Yes, supportive, especially recently. It has improved a lot. Other staff comments included; "It's getting a bit better. There's more of a team unit." "They're very easy to go and talk to if you have any problems" and "I love my job." Staff told us the company director visited the home on a daily basis.

Relatives we spoke with said they felt there had been an improvement in the service since our last inspection. Relatives told us they knew who the registered manager was but said, "The previous manager was a lot more accessible."

We saw evidence of monthly 'resident' meetings taking place The sign on display noted, 'These are chaired by the registered manager, so come and have your say'. We saw in the May 2016 meeting, people had been asked about the things they like doing. The notes of the meeting recorded 'Most said they were enjoying listening to music rather than television'. However, we noted during the inspection in one of the lounges the "Jeremy Kyle Show" was on television. The records of the June 2016 residents meeting stated, 'A new activities programme is in place to incorporate your suggestions'.

We saw the rating for the service from the last inspection report was displayed in the home as required. However, the rating was not shown on the provider's website.