Mimosa Healthcare (No 4) Limited

Valley Park Care Home

Inspection report

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Barnsley, S73 0HQ
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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?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

We carried out this inspection on 17 August 2015 and it was an unannounced inspection. This meant the provider did not know we were going to carry out the inspection. At the last full inspection carried out in July 2013, we found the home to be compliant with the regulations we inspected at the time.

Valley Park Care Home is registered to provide residential nursing accommodation for older people, including those living with dementia, for up to 57 people. The ground floor was a residential unit and the first floor was a nursing unit. The home is located in Wombwell, Barnsley and situated within landscaped gardens shared with two other care homes owned by Mimosa Healthcare. On the day of our inspection, there were 39 people living at the home, some who were living with dementia.

It is a condition of registration with the Care Quality Commission that the home has a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run. On the day of our inspection, the person managing

Summary of findings

the home was not registered as the 'registered manager' with CQC. The home manager and service manager confirmed that the home manager would register with CQC and we were made aware of the reasons for the delays in this taking place.

People and their relatives told us they felt the home was mostly safe but that there were some concerns with staffing levels. Comments made included; "I feel like [family member] is safe. I've never really had a reason to think they are not", " When a [care worker] goes off sick, the others are pulled out trying to see to everybody" and " I can't say it's not safe, but when they're short staffed these carers are rushing around and working even harder to get all the [people who lived at the home] sorted."

The home followed safeguarding procedures and concerns and alerts were investigated and responded to. Some care records contained personalised and relevant information for staff to assist in providing personalised care and support, though others didn't. Risk assessments and care plans were not always reviewed on a regular basis.

Staffing levels were, at times, too low to safely meet the needs of people who lived at the home. Some people who lived at the home, their relatives and staff members told us there were times when care assistants and nurses were stretched for time and could not meet people's needs in a timely manner.

Medicines were not safely stored at the home, with temperatures in the treatment room, where medicines were stored, regularly exceeding the required 25C level. Some topical medicines, such as creams, were stored in people's rooms, where no temperature checks were carried out to ensure they were stored safely.

There were no activities taking place on the day of our inspection and people who lived at the home and their relatives told us that this was the usual case. We spoke with the newly appointed activities co-ordinator, who walked around the home throughout the day and spoke with people to ask them what sort of activities they would like to take place at the home. The activities co-ordinator had lots of ideas on how to stimulate people, build relationships and enable people to avoid social isolation. We will check activities during our next inspection.

Staff told us they felt supported. However, we found staff supervisions and appraisals were not carried out on a regular basis. Training updates were not provided regularly and many of the staff members who worked at the home were out of date with their training requirements.

We found good practice in relation to decision making processes at the home, in line with the Mental Capacity code of practice, the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, although staff knowledge in this area was limited.

Checks of the home and fire safety were carried out regularly. Regular audits took place at the home although action plans were not developed from these to evidence action was taken with any concerns or issues identified. There was no trend analysis carried out on accidents, incidents or complaints to identify any patterns that could assist with service improvement. There was a lack of regular meetings for people who lived at the home, their relatives and staff members. These meetings and the involvement of others would be useful in developing the service provided at the home.

We found breaches in three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were breaches in; Regulation 12; Safe care and treatment, Regulation 17; Good governance; and Regulation 18; Staffing.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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 home was not always safe.

People were not always protected from harm as risk assessments were not always reviewed on a regular basis and maintained.

There were not sufficient numbers of staff on each shift, meaning people's needs were not always met in a timely manner.

The management of medicines was not safe due to storage temperatures exceeding the maximum for medicines storage.

Is the service effective?

Requires Improvement

The home was not always effective.

People were supported with eating and drinking, although risk assessments and care plans were not always kept up to date.

Staff training was out of date, with many staff members requiring refresher training. Staff supervisions and appraisals were not carried out on a regular basis.

Consent to care and treatment was sought in line with legislation and guidance.

Is the service caring?

Good

The home was caring.

We observed staff interacted with people who lived at the home in a caring way. Most care records we looked at demonstrated that people and/or their relatives were involved in the planning of their care.

People had their privacy and dignity maintained and promoted, with bedroom and bathroom doors being closed when staff were providing personal care.

There was information in place about any arrangements that had been made following a person passing away, where they had agreed to discuss this.

Is the service responsive?

Requires Improvement

The home was responsive.

People told us they felt able to complain, if the need ever arose. Everyone said they felt they could approach staff or the home manager if they wanted to complain.

There were no activities taking place at the home. However, a new activities co-ordinator had started working at the home on the day of our inspection, who was consulting with people on what activities they would like to see taking place. We will check activities at the home during our next inspection.

Summary of findings

Is the service well-led?

The home was not always well-led.

There was no manager in place at the home, who was registered with CQC as the 'registered manager'.

Meetings for staff, people who lived at the home and relatives did not take place on a regular basis.

Audits took place on a regular basis. However, action plans were not always developed, identifying any areas for improvement or attention. There was no trend analysis carried out of accidents, incidents or complaints.

Checks of the environment and safety were carried out, including fire safety checks and water temperature checks and maintenance logs were well maintained and up to date.

Requires Improvement

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

This inspection took place on 17 August 2015 and was unannounced. This meant the provider did not know we were going to carry out an inspection on the day. The inspection was carried out by two adult social care inspectors, one nurse specialist advisor and two experts-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.

Prior to our inspection, we contacted seven stakeholders including the local authority joint commissioning unit, the local authority contracts team and Healthwatch.

Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. Stakeholders we spoke with told us they had some concerns regarding infection control, staff training, records and medicines. This information was used so that we could check issues or concerns had been dealt with appropriately.

During our inspection we spoke with nine people who lived at the home and five of their relatives to obtain their views of the support provided. We spoke with 11 members of staff, which included the home manager, a registered nurse, care assistants and domestic staff.

We looked at documents including the care records of five people who lived at the home and the personnel records of five staff members including a nurse, a senior and three care assistants. We also looked at records relating to the management and monitoring of the home, including any audits carried out and reviews of care documents and policies.

Requires Improvement

Is the service safe?

Our findings

People we spoke with who lived at the home and their relatives told us they thought they, or their family members were safe living at the home. One relative said "Oh yes, I think she is very safe in this home. You see, she was too frail to be downstairs so she has been moved upstairs to the nursing unit." When asked about concerns over any ill treatment, this relative told us "Up until recently she would be able to tell you what was going on so I don't think there is any danger of that." Another visiting relative told us "Every time [family member] has a bruise, [staff] document it and explain to me how it happened." People we spoke with named staff members they trusted and would speak to if they had any concerns about safety. Relatives told us they would speak directly to the home manager if they had any concerns.

One relative said "I had my first holiday for seven years recently because I was sure that [family member] would be safe and well looked after while I was away. It was such a relief."

People we spoke with told us that they, or their family members received their medicines on time and in a way that met their needs.

We looked at care records to see how people were protected from bullying, harassment, avoidable harm and abuse that may have breached their human rights. We found some risk assessments were in place in some of the files we looked at. However, we also found some care records had documents present that were blank or had not been completed. For example, in one care record we looked at, some documents had not been completed, including risk assessments for choking, falls, moving and handling and bed rails. We spoke with the service manager about this, who told us they would ensure care plans were completed and up to date.

We found that risk assessments and care plans that were present were not always reviewed regularly. For example, in one care record we looked at, where the person was at 'very high risk' of developing pressure areas, no review had been carried out for almost two months. This person had experienced six falls within a three-month period and no review of the falls care plan had been carried out for over a month. We also found no evidence was recorded as to whether the home had requested involvement from the falls team to assist with this. We spoke with the home manager about this, who told us this was due to paperwork in the home being updated for everyone. However, care records should have been maintained and updated to ensure the person received care appropriate to their needs.

We looked at the accidents and incidents log held at the home. Information recorded included the date of the incident, the name of the person involved, what the incident was and actions taken. However, no information was recorded to demonstrate that accidents or incidents had been fully addressed and resolved. For example, one accident record stated a person had fallen out of bed. Actions recorded stated that bed wedges should be purchased and that an email was sent to the service manager, advising them of this. However, there was no further information recorded to state whether the person had received their bed wedges. This record was also not signed by the home manager. Another accident record we looked at stated a person had fallen and that a referral was made to the falls team. However, there was no further information recorded to state whether an appointment had been made or attended. Some of the accident and incident forms in the log did not contain a date, cause or manager signature. This meant that, although accidents and incidents were recorded, we were unable to find evidence that these were dealt with appropriately.

The information above demonstrated a breach of Regulation 12(1) & (2)(a,b&i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Safe care and treatment.

On the residential unit, people and relatives we spoke with thought there were enough staff to support with peoples' care needs at most times, although they could recall times when the unit was short staffed and care staff were very stretched. One person said "When someone (a care worker) goes off sick, the others are pulled out trying to see to everybody." A relative said "I can't say it's not safe, but when they're short staffed these carers are rushing around and working even harder to get [people who lived at the home] sorted."

A relative with a family member on the nursing unit told us they thought the unit was short staffed and that care assistants were stretched to provide timely care for people. They told us they were pleased to see that staff had managed to support their family member to have a shave that day. They also told us they had noticed that care staff

Is the service safe?

were doing extra shifts when other care assistants were off sick. They said "I think they work long enough hours already, without doing extra." Another relative said "[Family member] doesn't smell all that fresh sometimes and when I mention it [staff] say they will come, but then it takes ages, so they could do with more staff."

We checked staffing rotas at the home and carried out observations throughout the day to assess whether staffing levels were adequate. We saw that staffing rotas showed staff that were on duty during each shift, including a nurse on the nursing unit and a senior care assistant on the residential unit. However, we noted that staff sickness was not recorded on rotas, when a staff member had called in sick. One the day of our inspection, staffing rotas showed that a senior care assistant would be on duty on the residential unit of the home. However, the senior care assistant had called in sick that day and a replacement had not been brought into the home to cover the shift. This meant that, although staffing rota's showed adequate numbers of staff, this was not always a true reflection of staffing numbers present on each shift.

On the nursing unit a care assistant who worked regular day and night shifts told us that there were times when the nursing unit was not operating safely at night when some agency staff were employed. This was because some of the agency staff did not have the right skills and experience to deal with the high dependency needs of some of the people who lived at the home. This put extra pressure on care assistants to do all the high dependency work and they were not able to take any breaks. The care assistant said; "So when you're working with an agency nurse and agency carer at night who don't have the right skills, I would say the service isn't safe." They told us they thought some people with high dependency needs, and often communication problems, were also aware that their needs were not being met by these less knowledgeable staff. The care assistant told us they had reported these problems with some agency staff, on several occasions, to the home manager. Staff we spoke with who worked across both units told us that they thought the staffing levels and skill levels on the nursing unit were often lower than needed for safe care.

All of the staff we spoke with told us they had concerns about the level of knowledge and skills of some recently recruited staff from overseas. One care worker said "They don't know about the things you need to know when you're working in a care home. One worker didn't know what a leg bag was." During our inspection, we asked one of the newly recruited nurses about Ensure drinks (a drink given to people who are at risk of becoming nutritionally compromised) but they were unaware of what this was.

The information above demonstrated a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Staffing.

Medicines at the home were stored in a treatment room, which was adequately sized for safe storage of medicines. Temperatures of the refrigerator were recorded and we saw they were adequate to safely store medicines requiring refrigeration, such as eye drops and some creams. However, we looked at the temperature checks carried out of the treatment room and found temperatures to be above the maximum temperatures for medicines to be safely stored. For a full three month period, temperatures in the treatment room were regularly recorded as being above 25C. Most medicines require a storage temperature of below 25C, in line with recommendations from the Royal Pharmaceutical Society, to ensure the effectiveness of medicines is not compromised. We also found some topical medicines (creams) were stored in people's bedrooms, where no temperature checks were carried out. This meant it was not possible to evidence that these topical medicines were stored safely. We spoke with the home manager about this, who told us they were aware that temperatures regularly exceeded required temperatures for safe storage of medicines. We also spoke with the service manager about this, who told us they would look into possible solutions to ensure this was addressed.

We saw no copy of the British National Formulary (BNF) in the treatment room or on the medicines trolley. The BNF is a pharmaceutical reference book that contains information and advice on prescribing and pharmacology, along with specific facts and details about many medicines available on the National Health Service (NHS), including indications, contraindications, side effects, doses, legal classification, names and prices and any other notable points of available drugs. We asked the home manager about this, who produced a copy of the home's BNF for us. We noted that this was the 2012 edition. Up to date copies of the BNF should be available in nursing care areas to enable staff to check for routine information and side effects of medicines.

Requires Improvement

Is the service safe?

The above information demonstrates a breach of Regulation 12(1) & (2)(e,f&g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations

We looked in people's care records at care plans relating to medicines. We found each care record contained care plans with details of the medicines that had been prescribed, when they required administration and a dependency score to show how much support each person required. Information was also present for staff, where people were administered medicines through a Percutaneous Endoscopic Gastronomy (PEG) tube. PEG is an endoscopic medical procedure in which a tube is passed into a person's stomach through the abdominal wall, most commonly to provide a means of feeding and medicine administration when oral intake is not adequate. Most care plans we looked at had been reviewed regularly and on a (at least) monthly basis. However, two of the care records we looked at contained medicines care plans that had not been reviewed for almost two months. We spoke with the service manager about this, who told us they would address this and ensure all medicines care plans were reviewed and maintained so that they were up to date.

We checked Medication Administration Records (MAR) and found they were completed and well-maintained. Each person had a photograph of themselves on their own MAR charts so that they were identifiable to staff. People's preferred method of receiving their medicines was recorded, for example, in a pot or on a spoon. However, these instructions were written in fibre tip pen on a plastic laminated sheet, which were smudged and faded, making it difficult to read. When medicine was administered, MAR charts were signed by the administering staff member. Where medicines were unused or a person had refused to take them, this was written in a book so that a record of all medicines was maintained. We carried out a stock check of eight medicines to see if stock levels were the same as recorded on MAR charts. We found all eight medicines checked were correct and in line with information recorded on MAR charts.

Staff we spoke with told us about the different types of abuse and how they would report any concerns. We saw handover sheets were completed, which contained information about how every person who lived at the home was and any concerns that staff on the next shift needed to be aware of. Safeguarding policies and procedures were up to date and had been reviewed. This meant staff knew about abuse, how to report any concerns and that there were methods used to share information about possible risks for people.

The safeguarding log held at the home contained information about safeguarding concerns and alerts that had been raised. Actions identified as a result of safeguarding investigations were recorded on meeting minutes, which were kept in the file along with the concern. We found no evidence to demonstrate that actions had been addressed and completed. However, although details of actions taken were not recorded, we saw that changes had been made at the home to improve the service, following safeguarding meetings. For example, following one safeguarding concern regarding care planning, we found new care documents had been implemented for people who lived at the home so that incidents that led to the concern being referred to the local authority safeguarding team did not reoccur. We found no evidence to demonstrate that safeguarding concerns and alerts were regularly reviewed to identify and themes or trends. This meant that, although actions were not recorded and evidenced, the home took action in response to safeguarding concerns and alerts but that no trend analysis of safeguarding concerns took place to identify any patterns.

We looked at the staff personnel records of five staff members who worked at the home, including a nurse, a senior and three care assistants. We found adequate pre-employment checks had been carried out by the registered provider. These checks included photographic identification, proof of address and right to work in the United Kingdom, (at least) two reference checks from previous employers to confirm satisfactory conduct and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups, by disclosing information about any previous convictions a person may have. This meant the home followed safe recruitment practices to ensure the safety of people who lived at the home.

Requires Improvement

Is the service effective?

Our findings

People we spoke with could not recall being given information about the home before they moved in, but most of them told us that relatives probably had that information. Two relatives we spoke with told us they had enough information before they agreed to a placement for their family member. People also told us they thought that care staff were meeting their care needs but that they did not know much about their care plans, though some people told us their relatives dealt with their care planning. Relatives said they were involved as much as they wanted to be.

One person we spoke with said; "I'm a very independent person and I only need help with some things, like my catheter. The carers just let me get on with what I can do and that suits me fine." Another person said "The carers know me really well and we have a good routine going."

People we spoke with on the residential unit told us they had choices about what they ate, when they went to bed, when they got up and where to sit during the day. On the day of our visit we saw that some people chose to spend some time in the garden area. Most people sat in the lounge during the day. We spoke to one person who preferred to spend their time in their bedroom. They said "The carers always ask me if I want to go into the lounge, but at the moment I prefer to be in here by myself." Another person told us they preferred to spend their day in their wheelchair, rather than in an armchair. They said "The carers ask me if I want to sit in a comfy chair, but I tell them I think my wheelchair is more comfortable for me."

We asked people and their relatives if they were supported to access healthcare professionals, when needed. One relative told us "There's no question about it, they always get a doctor when needed" and another relative said "Yes they do get a doctor. They either phone me or tell me next time I visit".

We looked at the staff training matrix to see if staff received suitable and ongoing training. We found several areas where staff had not completed initial training or had not attended required refresher training courses. We found, out of 45 staff members, 13 staff members required training in Health and Safety, 11 required training in Control Of Substances Hazardous to Health (COSHH), 34 required training in pressure care/tissue viability care, 40 required training in Safeguarding, 27 required training in the Mental Capacity Act and Deprivation of Liberty Safeguards, 22 required training in Moving and Handling and 5 required training in Infection Control. This demonstrated the home did not ensure staff were up to date with training, including some mandatory training.

Supervisions are accountable, two-way meetings that support, motivate and enable the development of good practice for individual staff members. Appraisals are meetings involving the review of a staff member's performance, goals and objectives over a period of time, usually annually. These are important in order to ensure staff are adequately supported in their roles. In all five staff personnel files we looked at, we saw supervisions had not been carried out on a regular, consistent basis. For example, in one staff personnel file we looked at, we saw supervision dates recorded as having taken place on 05 March 2013, 12 March 2013, 01 August 2013 and 07 February 2014 but none since. The home manager showed us a supervision matrix with information about recent supervisions that had taken place at the home. We saw that this staff member had a date recorded next to their name for when the last supervision had taken place. The supervision matrix showed that this staff member had had a supervision on 06 February 2015 but none since. We saw no evidence in the staff personnel file to demonstrate that this supervision had taken place or been recorded. We also found no evidence of an appraisal having taken place in four of the five staff personnel files we looked at. In the staff file where we found a record of an appraisal having taken place, this was dated 09 August 2013. There was no evidence of an appraisal after that date. This meant staff were not adequately supported and did not receive regular supervisions and/or appraisals.

The above demonstrates a breach of Regulation 18 (1) & (2)(a&b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes and services. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

We found the home to be acting within MCA 2005 legislation and observed people being asked for consent

Requires Improvement

Is the service effective?

before any care and support was provided. In care records we looked at, there were details about the person's mental capacity, which was reviewed on a regular basis to ensure they were still relevant, particularly if the person had fluctuating capacity to make decisions. For example, we saw in one care record a mental capacity assessment with information stating that the person lacked capacity to make decisions in certain areas but not in others. Following these assessments, best interest meetings had been held with relevant healthcare professionals and family members, where appropriate. Best interest meetings are held to ensure that any decisions made about the care, treatment and support of a person are done so in their best interests. People who were deprived of their liberty had appropriate DoLS authorisations in place or had DoLS applications submitted to the local authority for authorisation. Staff we spoke with were able to explain the main principles behind the MCA 2005 and DoLS and what this meant for people who lived at the home, although understanding of this was limited. This demonstrated the home acted in line with the MCA 2005 and DoLS.

In care records we looked at, we saw nutritional assessments were completed to assess whether the person was at risk of becoming nutritionally compromised. Care records also contained details of special dietary needs that people may have had, such as a pureed diet of feeding via a Percutaneous Endoscopic Gastronomy (PEG) tube. PEG is an endoscopic medical procedure in which a tube is passed into a person's stomach through the abdominal wall, most commonly to provide a means of feeding and medicine administration when oral intake is not adequate. However, we saw that one of these records was not maintained or reviewed on a regular basis. This care record showed that the person was at risk of becoming nutritionally compromised and a Malnutrition Universal Screening Tool (MUST) had been completed and last reviewed on 01 June 2015. MUST is a screening tool used to identify adults, who are malnourished, at risk of malnutrition or obesity. It also includes management guidelines which can be used to develop a care plan. We also saw this person had last had their weight recorded on 01 June 2015, over two months before our inspection. This meant this person did not have their nutritional and hydration needs monitored to ensure effective care and support were given. We saw tea trolleys were brought round to people throughout the day with a choice of tea, coffee or juice to drink and snacks of biscuits or fruit available.

Everyone we spoke with on the residential unit told us they enjoyed the food and they always had choices of food and enough to eat. Two people told us they had put on weight since coming to live at the home. One person said "It's all these good meals that have given me this tummy, but I needed some meat on my bones."

We observed lunchtime in two of the dining rooms at the home. We found mealtimes were not rushed and the dining areas were bright, airy and well-decorated for people with condiments available on tables for people to use. We saw that care assistants knew the food preferences of people who lived at the home. We saw care assistants promoting people's independence by offering assistance appropriate to their needs. This demonstrated people had a good dining experience and were supported to eat at mealtimes.

Where required, referrals were made to, and assistance sought from appropriate healthcare professionals. We saw care records contained details of visiting healthcare professionals that the person had seen and details of visits. For example, in one care record we saw details of a referral made for the person to a tissue viability nurse due to pressure areas. This record showed what the tissue viability nurse had found and advice given to staff to enable them to provide care and support to the person to manage their pressure areas adequately. This demonstrated the home supported people to maintain good health and have access to relevant healthcare services.

Good

Is the service caring?

Our findings

People we spoke with told us they received good care and were very complimentary about the care staff. People told us that care staff were kind, caring, patient and respectful. Comments about care staff included; "They're all marvellous, I can't speak highly enough of them", "I think the carers are lovely people and they work bloomin' hard all day and all night", "I'm glad I live here because I don't think you'd get a better set of carers anywhere else on earth", "They're lovely people. They're just like family to me" and "You get plenty of TLC here. If you were to give medals, there wouldn't be enough gold in Fort Knox."

One person who lived at the home, who was drinking a can of Guinness said "The staff are very caring, I can always have a Guinness with my lunch if I want one." This person was sat in the dining room by themselves. A member of staff told us "He likes to sit here on his own and does not want to interact with the other residents much."

All the relatives who we spoke with made decisions regarding the care of their family member and said they were consulted by staff. One relative said "Yesterday they rang to say they had taken a wedding ring off as it was cutting into [family member's] finger and they gave it to me when I came in today". When the family member lived downstairs at the home, the relative told us "We asked if they could move her upstairs, we (relative and family member) wanted her up here and they did." Another relative said "I have power of attorney over [family member's] affairs and see to the money and stuff, but don't really get involved in care plan or anything."

We carried out observations throughout our inspection and saw that people were treated with kindness and compassion. People looked clean and well groomed, with the gentlemen having been shaven and the women with their hair done. We did not hear any staff member discussing people's care needs in earshot of others. When personal care was provided, bedroom and bathroom doors were closed to ensure the person had their privacy and dignity maintained. This demonstrated staff were respectful of people's privacy and dignity.

In some of the care records we looked at, we found evidence to demonstrate that people and/or their relatives were involved in decisions about their care and support. Most care records contained details of the person's life history and preferences to enable staff to provide personalised care and support. For example, in one care record we looked at, we saw a life history document had been completed that had information regarding the persons favourite holidays, toys, jobs, drink, music and hobbies. We also saw information about what made the person laugh and what they would consider to be a 'treat'. A document titled 'A day in the life of…' contained details of what each day was like for the person, ranging from the time the person liked to get up in the morning and go to bed at night, their daily routine and what they liked to do throughout the day. We saw evidence in one care record that a relative, who had lasting power of attorney had been involved in decisions about their family members' care and support due to the fact that the person living at the home lacked capacity to make these decisions. A lasting power of attorney (LPA) is a legal document that lets a person appoint one or more people (known as 'attorneys') to help them make decisions or make decisions on their behalf. There are two types of LPA's; 'health and welfare' and 'property and financial affairs'. This demonstrated information was present in some care records to enable staff to provide personalised and person-centred care and support. However, in some other care records we looked at, we found the life history document and lifestyle profile document to be blank and there was no evidence that people and/or their relatives were involved. We spoke with the home manager and the service manager about this, who told us all care records were currently being reviewed and new paperwork was being implemented. They told us that new care records would include this information when reviews had been completed.

The home manager, staff members, people who lived at the home and their relatives all told us there were no restrictions on when people could visit the home.

No information regarding advocacy services was provided to people as a matter of routine but this was made available to people, when required. An advocate is a person who speaks or writes on someone's behalf when they are unable to do so for themselves.

A 'Do Not Attempt Cardio Pulmonary Resuscitation' form (DNACPR) is used if cardiac or respiratory arrest is an expected part of the dying process and where CPR would not be successful. Making and recording an advance decision not to attempt CPR will help to ensure that the person dies in a dignified and peaceful manner. In care

Good

Is the service caring?

records we looked at, where required and appropriate, DNACPR forms were in place, where either an advanced decision had been made by a person who lived at the home when they had capacity or by a relevant healthcare professional, if the person lacked capacity to make this decision. DNACPR forms contained information about the person's condition and reasons why CPR would not be attempted. These forms also contained dates the forms were completed and reviewed and had signatures of relevant professionals who had been involved in the decision, including GP's. Where people had been willing to speak about it, details of any funeral arrangements were present in care records. This meant the home had arrangements in place to ensure people who passed away were cared for and treated in a sensitive way, respecting people's preferences.

Requires Improvement

Is the service responsive?

Our findings

On the day of our inspection a new activities co-ordinator had started in post that day. They spent the day speaking with people, getting to know them and asking them what sort of activities they would like to do. The new activities co-ordinator told us they had never done this sort of work before and had no training for the job, but they were enthusiastic about the new challenge.

On the day of our inspection, there were no activities taking place at the home. People told us that this was usually the case. One person told us that staff from another care home had led some activities, such as bingo or games on some occasions. One person said "It does get boring sitting around all day, but you can always have a chat with the staff." Another person said "It's been a bit dull recently – I'm looking forward to a few sing-songs soon."

Some people told us about recent trips out to Cleethorpes and Wentworth Garden Centre that people had enjoyed. One person said "It was lovely to go to Cleethorpes – it was a roasting day and I think some of the staff came on their day off to help."

One person told us they were able to go out of the home independently, using the dial-a-ride scheme. This person said "I go out to Barnsley once a week and I really enjoy it." However, another person told us they would like to go out of the home, but they could not go without a member of staff. They said "The staff are too busy to go out with me, so I'm stuck. I really need more exercise, so it's not a good situation."

We saw that most people on the residential unit spent their time in the lounge area, and that some people sat outside in the garden for part of the day as it was a warm day. We saw that a TV was playing in the lounge on the residential unit, but no one was watching it and we did not see any staff asking if anyone wanted to watch a particular programme. We did not hear any music playing, apart from in people's bedrooms. On the nursing unit in the afternoon we saw that five people were asleep in the lounge and the TV was playing with no one watching it. This demonstrated that activities were not always available for people to take part in at the home to build and maintain relationships and avoid social isolation. However, due to the newly appointed activities co-ordinator commencing employment at the home, it is anticipated that activities for people will increase, which we will follow up on during our next inspection.

We asked people if they felt able to complain, should the need arise and if they knew how to complain. One person we spoke with told us "I would tell the staff first and then go to manager." Another person said "Well just go straight to the top. I don't know who the 'top' is because the company has changed hands or something, but I would find out." The relative of one person who lived at the home and had had Methicillin Resistant Staphylococcus Aureus (MRSA) earlier in the year told us "I did complain about that. There was no notice on the outer door of the home so that you could make a decision about whether to visit or not, and no one had informed me of the problem. It was quite a shock when I got to [family members] room and saw the door was shut with a notice on about barrier nursing." Barrier nursing is a set of stringent infection control techniques used is to protect healthcare staff against infection from people, particularly those with highly infectious diseases.

Some of the care records we looked at contained personalised information and were written with the involvement of people who lived at the home and their families, where possible. There was information about the persons past life, interests and preferences. However, in some of the care records we looked at, we saw these documents were blank. The home manager told us they were in the process of implementing new paperwork and all records would be completed when this was done.

We looked at the complaints file held at the home and found concerns and complaints were addressed and responded to. There was a complaints log summary at the front of the file with details of the date, name of the person involved, the complaint and the response. These were also signed by the home manager to show actions had been completed. The home manager told us they were implementing a compliments book to be left in the reception area of the home, for people to write in with any feedback. Staff were unsure of the processes for making complaints but told us that they could access policies and procedures to find this out. This demonstrated complaints were addressed and responded to in a timely manner and that arrangements were being put in place to encourage feedback.

Requires Improvement

Is the service responsive?

People and their relatives told us they felt able to approach staff and the home manager to provide any feedback or to raise concerns. One person told us “Yes, I can approach any of the staff. They’re all very pleasant.

Requires Improvement

Is the service well-led?

Our findings

Most people we spoke with who lived at the home knew who the home manager was and told us they had seen him walking around the building and speaking with people.

We asked people and their relatives if there was a good culture at the home and if they were involved in decisions relating to the home. One relative we spoke with said "Yes, there is a good culture. We can ask for what we want and, if possible, we can get it." Another relative we spoke with told us "Every so often a survey comes to us through the post and we complete it and send it back through the post" and another relative said "Yes, we get something through the post by a holding company – but I don't think anything ever happens from what is written."

We asked people and their relatives what improvements could be made to the home. Comments included "More staff so they're not pulled out all the time", "More staff so someone can help me get out more", "More trips out", "More things to do in the day" and "I think the staff should get more recognition because they do a great job."

We asked the home manager for minutes of staff meetings. The home manager brought us a file that they said contained minutes of all the meetings at the home. We found no minutes of staff meetings. Minutes from a 'heads of department meeting' were present but these were from January 2014. There were no 'heads of department meeting' minutes from after this date. This meant it was not possible for us to evidence that staff meetings were used for involving staff in the development of the home, for staff to question practice or raise concerns. We spoke with the home manager about this, who told us that they planned on having staff meetings frequently in the future, including meetings for health and safety and clinical governance. However, none of these meetings had taken place as of the date of inspection.

We saw minutes of 'residents meetings' from February 2015 and June 2015. Relatives meetings had taken place at the home in February 2013, February 2014 and June 2015. This meant meetings were not accessible for people who lived at the home and relatives on a regular basis to encourage open communication and to enable people to be involved in developing the home or in raising concerns.

Audits carried out at the home included audits of finance, health and safety, complaints, recruitment, medicines, care planning, infection prevention and control, food safety, safeguarding, staff files, accidents and incidents and staffing. However, we found that action plans had not been completed following these audits to demonstrate any actions needed to resolve any issues or problems identified. We also found there was no trend analysis carried out of accidents, incident, complaints and compliments as a means to continually improve the service provided.

The above information demonstrates a breach of Regulation 17 (1)(2)(a,b,c,e&f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the maintenance logs kept at the home and saw that these were well maintained, with audits being carried out on a regular basis. This included audits of the home environment, equipment safety and fire safety checks. We saw water temperature audits were carried out monthly, as were audits of wheelchairs, call bell systems, window restrictors and extractor fans.

It is a condition of registration with the Care Quality Commission (CQC) that the home have a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run. On the day of our inspection, the person managing the home was not registered as the 'registered manager' with CQC. The home manager and service manager confirmed that the home manager would register with CQC and we were made aware of the reasons for the delays in this taking place.

We asked staff if they felt there was openness and transparency at the home. Staff told us they felt communication was open and that they were able to speak with the home manager. One staff member told us "Morale was so low before the new manager came, that I was thinking of leaving, but it's so much better now."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 12.—(1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— (a)assessing the risks to the health and safety of service users of receiving the care or treatment; (b)doing all that is reasonably practicable to mitigate any such risks; (c)ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; (d)ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way; (e)ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way; (f)where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs; (g)the proper and safe management of medicines; (h)assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated; (i)where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing 18.—(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. (2) Persons employed by the service provider in the provision of a regulated activity must— (a)receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform,. (b)be enabled where appropriate to obtain further qualifications appropriate to the work they perform, and. (c)where such persons are health care professionals, social workers or other professionals registered with a health care or social care regulator, be enabled to provide evidence to the regulator in question demonstrating, where it is possible to do so, that they continue to meet the professional standards which are a condition of their ability to practise or a requirement of their role.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17.—(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— (a)assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);.

This section is primarily information for the provider

Action we have told the provider to take

(b)assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;.

(c)maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;.

(d)maintain securely such other records as are necessary to be kept in relation to—.

(i)persons employed in the carrying on of the regulated activity, and.

(ii)the management of the regulated activity;.

(e)seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;.

(f)evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).

(3) The registered person must send to the Commission, when requested to do so and by no later than 28 days beginning on the day after receipt of the request—

(a)a written report setting out how, and the extent to which, in the opinion of the registered person, the requirements of paragraph (2)(a) and (b) are being complied with, and.

(b)any plans that the registered person has for improving the standard of the services provided to service users with a view to ensuring their health and welfare.