Care Quality Commission

Bupa Care Homes (GL) Limited

Burley Hall Nursing Home

Inspection report

Cornmill Lane, Burley-in-Wharfedale LS29 7DP
Tel: 01943 863363
Website: www.example.com

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 3 and 5 November 2015 and was unannounced. At the last inspection on 31 January 2014 we found the home was meeting the regulations.

Burley Hall Nursing Home provides nursing and personal care for up to 51 older people, some of who are living with dementia. There were 48 people using the service when we visited. Accommodation is provided in two units – Greenholme unit accommodates up to 17 people living with dementia and Wharfedale unit accommodates up to 31 people with nursing needs. There are 45 single rooms and three shared rooms, which are currently used for single occupancy. There are communal areas on each unit and access to garden areas.

The home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Before the inspection we received a number of concerns stating there were not enough staff to meet people's needs, particularly on Wharfedale unit. Our discussions with people, their relatives and staff and our observations during the inspection confirmed this. We found people's needs were not met in a timely way and duty rotas showed staffing levels had fallen below the levels stated

Summary of findings

by the registered manager on many occasions in the weeks prior to the inspection. There was no tool used to calculate the staffing levels and the registered manager told us staffing levels were based on numbers and people's dependency levels were not considered. We found this was a breach of regulation as there were not enough staff to meet people's needs.

People told us they felt safe in the home and our discussions with staff showed they understood the safeguarding procedures; however we found some incidents had not been referred to the local authority safeguarding unit or notified to the Commission. We found this was a breach in regulation as safeguarding incidents were not always recognised or reported appropriately.

We found systems in place to manage medicines were not always safe which meant people were at risk of not receiving their medicines when they needed them. We found this was a breach in regulation as people's medicines were not managed safely.

Recruitment procedures ensured staff were suitable and safe to work with people. Staff received the induction, training and support they required to carry out their roles and meet people's needs. Nurses on Greenholme unit were involved in a project with Bradford University to heighten staff awareness of the needs of people living with dementia and ensure their individual needs were met.

The registered manager understood the legal requirements relating to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). An authorised DoLS was in place for one person and eleven other applications had been made for DoLS authorisations.

We found the home was clean, well-maintained and decorated and furnished to a high standard. People's rooms were personalised and communal areas were comfortably arranged so people could sit in small groups relaxing and chatting with each other.The home employed activity co-ordinators and there was a varied activity programme of events both in house and out in the community.

People's feedback about the food was mixed; some people praised the food, whereas others were less positive. Menus showed a wide variety of meals and mealtimes were well organised with staff providing people with assistance as required. However, we found people's nutritional needs and weight were not monitored or reviewed to make sure they were receiving sufficient to eat and drink. We found this was a breach in regulation as people's care needs were not being met.

People praised the staff describing them as 'excellent', 'extremely kind' and caring. We saw staff maintained people's privacy and dignity and encouraged their independence. People had access to healthcare services and professionals we spoke with confirmed staff acted upon advice given.

We found differences on the two units in how care was planned and delivered. On Greenholme unit nurses were working with staff to ensure people received person-centred care using the knowledge gained from the project work with Bradford University. However, on Wharfedale unit we found care was not responsive to people's needs and focussed more on the completion of tasks. This meant people's individual needs and preferences were not always recognised or met. We found this was a breach in regulation as people's care needs were not being met.

There was a complaints procedure and we saw evidence which showed the procedure had been followed in relation to some complaints. However, during the inspection we were made aware of two complaints which had not been dealt with or responded to appropriately. We found this was a breach in regulation as complaints were not being dealt with appropriately.

Accidents and incidents were recorded, however there was no overall analysis to identify trends or themes and consider 'lessons learnt' to reduce the likelihood of re-occurrence

People, staff and relatives gave mixed feedback about the leadership and management of the home. Some said they found the registered manager approachable, responsive and effective, whereas others stated the opposite describing them as someone who did not listen, was unapproachable and ineffective. Systems were in place to monitor and assess the quality of the service such as audits of medicines and care plans, as well as regularly monitoring visits by senior managers. However,

Summary of findings

these systems were not effectively used to identify and address areas for improvement to ensure that the quality of care continually improved. We found this was a breach in regulation as there was not good governance.

We identified six breaches in regulations relating to staffing, medicines, complaints, safeguarding, person-centred care and quality assurance. You can see what action we told the provider to take at the back of the full version of the report.

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

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?

Inadequate

The service was not safe.

People were not kept safe as there were not enough staff to meet people's individual needs.

Although staff had been trained and understood safeguarding procedures, incidents were not always recognised or reported, which placed people at risk of harm.

Medicines management was not always safe and effective.

The environment was clean, well maintained and decorated and furnished to a high standard.

Is the service effective?

Requires improvement

The service was not consistently effective.

People's weight and nutritional and hydration needs were not monitored effectively, which placed people at risk of not receiving sufficient quantities of food and drink to maintain their health. People gave mixed feedback about the food.

Staff were inducted, trained and supported to ensure they had the skills and knowledge to meet people's needs.

The legal requirements relating to Deprivation of Liberty Safeguards (DoLS) were being met. People were supported to access health care services to meet their individual needs.

Is the service caring?

Good

The service was caring.

People praised the staff describing them as kind, caring and compassionate. People were relaxed and comfortable around staff.

People's privacy and dignity was respected and maintained.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People did not always receive person-centred care which met their individual needs.

A varied activity programme was provided both in-house and out in the community.

Complaints were not always recognised, recorded and dealt with appropriately.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led.

There was a registered manager, however we found a lack of leadership, poor communication and ineffective quality assurance systems meant people did not always receive the care and support they required. This had not been identified or addressed at provider level.

Burley Hall Nursing 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 3 and 5 November 2015 and was unannounced. On the first day the inspection team consisted of two inspectors and on the second day three inspectors attended.

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 as the inspection was planned at short notice due to a number of concerns we had received about the service.

We spoke with seven people who were using the service, seven relatives, six nurses, 12 care staff, two domestics, the cook, the clinical services manager and the registered manager. We also spoke with two healthcare professionals who were visiting the home at the time of our inspection.

We looked at ten people's care records, four 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

Prior to the inspection we received a number of concerns about the staffing levels. We were told there were not enough staff to meet people's needs.

The registered manager told us the usual staffing levels on Wharfedale unit, were two nurses and five care staff between 8am and 2pm and one nurse and five care staff between 2pm and 8pm and on Greenholme unit one nurse and three care staff from 8am until 8pm. Night staffing levels were two nurses and four care staff across both units. The registered manager acknowledged there had been staff shortages over the previous five weeks due to sickness and staff vacancies. They said shifts had been covered by staff working additional hours and the use of agency staff. They told us four care staff and a night nurse had been recruited which they felt would address the shortfalls.

Staff we spoke with raised concerns about the staffing levels on Wharfedale unit. They told us over the past two months staffing levels had regularly fallen below those stated by the registered manager and duty rotas we reviewed confirmed this.

When we inspected the staffing levels were as stated by the registered manager. However, our observations concluded these levels and deployment of the staff on Wharfedale unit were insufficient to meet people's needs in a timely way. For example, we saw one person at 10.30am had their breakfast on a tray in front of them. The food and drink were untouched and the porridge and tea were cold. When we went back to check on this person 90 minutes later we found the same situation and at this point we alerted staff. We saw staff were constantly busy throughout the morning and at 12 midday staff told us they still had six people who needed assistance with washing, dressing and getting up. Staff we spoke with told us this was not unusual.

We saw the two nurses on Wharfedale unit were busy throughout the morning giving out medicines and dealing with healthcare issues such as organising GP visits. The nurses we spoke with told us the morning medicine round took up to two and half hours, which was confirmed by our observations. In addition to this there were a number of people who had time-specific medicines which had to be administered at regular intervals throughout the day. Two care staff were allocated to give out breakfasts which started at 8.30am and staff told us six people needed help from staff with eating and drinking. Staff told us and we saw that this process lasted two hours. This meant until breakfasts were completed there were three care staff to assist 31 people with their personal hygiene needs and to get up.

Although additional staff were employed to support the care staff by giving out drinks and snacks in the morning and afternoon, the benefit was limited. For example, the staff member undertaking these tasks told us they were not able to assist people with their drinks as they had not been trained to do this, they could not go into a person's room if the door was closed and they were not able to add thickener to drinks. This was confirmed by other staff we spoke with who said this meant this support had to be completed by the care staff.

People we spoke with on Wharfedale unit told us they felt there were not enough staff. One person said, "Staff are very busy, they never stop. Means we have to wait sometimes." Another person said, "My only bone of contention is getting up when I'd like to as I can't but it's not the staff's fault as they're busy." A further person said, "They (staff) work hard but at times there's just not enough of them." Another person said, "It's not bad here. They're just short of staff." A further person told us about delays at meal times, they said "I think they (the staff) go on strike, sometimes it can be an hour before we get away from the table". A relative told us they felt there was not enough staff which they felt impacted on when people could get up and go to bed. A visiting healthcare professional told us relatives had expressed concerns with them about staffing levels. This was a breach of the Regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff recruitment processes were thorough and ensured staff were suitable to work at the home. We looked at four staff employment files and found all the appropriate checks had been made prior to starting work. Staff told us the recruitment process was thorough and done fairly. They said they were not allowed to work until all relevant checks on their suitability to work with vulnerable adults had been made. They said they felt well supported by the registered manager and senior management team and enjoyed working at Burley Hall.

Inadequate

Is the service safe?

We saw there was a disciplinary procedure in place and the registered manager told us if they found a member of staff was no longer suitable to work in a health or social care setting they would make a referral to the appropriate agency, for example, the Disclosure and Barring Service.

We found inconsistencies in medicines practices meant we could not be assured people were receiving their medicines safely or when they needed them. For example, one person's insulin dosage on the medicine administration chart had been crossed out and a higher dose handwritten. This amendment was not signed or dated and did not correlate with the prescription label on the box. The nurse was unable to provide any written authorisation of the change of dose and subsequently contacted the GP who faxed confirmation that the dose had been increased on 7 October 2015. Another person was prescribed a medicine to be given three times a day yet when we checked the stock there was a large supply left and when we asked the nurse why, they said they didn't give the person this medicine very often as they felt the person did not need it. Another person's care records showed the GP had stated in September 2015 the person was to start taking a calcium supplement daily, yet when we looked at this person's medication administration record (MAR) it was not prescribed. The nurse told us they did not know anything about this and said they would follow it up with the GP.

The nurse told us topical medicines, creams and lotions were kept in people's rooms and applied by the care staff. We saw protocols were in place which detailed what to apply, where and when and to sign when done. However, when we checked on both units these had not been completed correctly. For example, one person's protocol identified where the cream should be applied but did not state how often and there were no staff signatures to show the cream had been applied.

We looked at the records for two people who received their medicines covertly and found inconsistencies. For one person the documentation was well completed and the covert medication assessment showed involvement of the GP, community matron and pharmacist, listed the medicines to be given covertly and how. A Mental Capacity Act (MCA) assessment and best interest decision making documents were completed which showed the involvement of a relative who had Lasting Power of Attorney. For the other person the covert medication assessment was undated and incomplete. There was no information to show who was involved in making this decision or how to give the medicines covertly and a MCA assessment and best interest decision documents had not been completed

There was conflicting information about the administration of prescribed thickeners with regards to the amounts to be used. This meant people were at risk of receiving fluids which had not been thickened to the required consistency to meet their health care needs. For example, for one person the MAR stated to give the thickener 'as directed', the speech and language therapist (SALT) advice stated 15mls thickener to every 150mls fluid which the label on the thickener showed equated to one scoop. The person's care plan stated half a scoop to 100mls of fluid. When we asked the nurses about these discrepancies they were unable to provide an explanation.

Two nurses we spoke with could not recall having completed any medicine training, although one of the nurses told us they had undertaken a competency assessment in the last year. The other nurse told us they had not completed a competency assessment. This was a breach of the Regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found there were safe systems in place for the storage of all medicines and the management of controlled medicines.

We found individual risks to people were identified in the care records we reviewed, for example with regard to the use of bed rails, nutrition, moving and handling and falls. Yet the care plans did not always reflect the action to be taken to manage the risk. For example, one person was identified as at risk of pressure damage but there was no care plan in place for the prevention of pressure ulcers. We also found there were no arrangements in place for continually reviewing accidents and incidents to ensure themes were identified and any necessary action taken.

People told us they felt safe in the home. Our discussions with staff showed they had a good understanding of the different types of abuse and would have no hesitation in reporting concerns to senior staff or the registered manager. The provider had notified us of one safeguarding incident at the service since 1 January 2015. Yet records we reviewed and discussions we had with staff raised other safeguarding concerns which had not been reported to

Inadequate

Is the service safe?

safeguarding or notified to CQC. This meant staff were not always identifying, reporting or dealing with safeguarding issues appropriately which put people at risk of harm. This was a breach of the Regulation 13 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the environment was decorated and furnished to a high standard, well maintained and clean with no discernible odours. We found up-to-date safety certificates were in place for the passenger lift and hoists, as well as gas safety, legionella and electrical wiring installation.

Requires improvement

Is the service effective?

Our findings

We had concerns about how staff monitored people's weight and ensured their nutritional intake was sufficient. For example, we saw one person who was low weight and had a low body mass index (BMI) was to be weighed weekly and was on food and fluid charts. We looked at the food charts for this person from 27 October to 4 November 2015 and found inconsistencies. For example, on one day the only food recorded was breakfast, on other days the record showed a poor intake and it was difficult to ascertain exactly what the person had eaten because food amounts were not clear with entries stating 'soup, main, sweet – all'. We looked at the weight records and saw the person had been weighed monthly not weekly. The nurse we spoke with confirmed this person had not been weighed weekly and acknowledged they should have been.

We looked at the fluid charts for another person whose records stated they were prone to urine infections which meant it was important they were kept well hydrated. The charts were incomplete, did not specify a target input and showed a poor fluid intake. For example, on 2 November 2015 records showed the person had received four drinks amounting to a total intake of 300mls, on 3 November 2015 the total fluid intake was 390mls and 620mls on 4 November 2015. For another person the fluid chart dated 26 October 2015 showed a total fluid intake of 900mls with no intake recorded after 5.30pm and on 27 October 2015 a total fluid intake of 750mls with no intake recorded after 2:30pm.

A nurse told us they checked the food and fluid charts every day to make sure they had been completed properly but there were no signatures to show this and no evidence in the care records to show that people's nutritional and hydration needs had been reviewed as a result of these checks. This meant although records were maintained, no one responded to the information recorded. This was a breach of the Regulation 9 (3) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People gave mixed feedback about the food. One person described the food as 'iffy' and said, "It's very variable. I had a hotpot the other day and it was mainly gristle." Another person said, "The food is okay. It's settled down now after a change of chef." A further person said, "I like the food here. It's always tasty." One person said, "I love the porridge here it so creamy and I have it with syrup."

We observed the lunchtime meal in the dining room on both units. The tables were set with tablecloths, napkins, glasses and condiments. The cook who served the meal on Wharfedale unit was very attentive to people's needs and aware of their preferences and we heard them reminding staff to give people a choice. The food looked and smelt appealing and we heard people saying they enjoyed it. We saw staff offered people hot and cold drinks. We saw on both units staff asked people if they required assistance, such as cutting up their food, and provided one to one support for people who needed help with eating their meals. We saw this was done sensitively by most staff who sat with people individually chatting and explaining what the food was, asking if they were enjoying it and if they were ready for any more. Yet we saw one person was assisted by a staff member who hardly spoke with them and on two occasions left the person partway through the meal to do something else without any explanation or apology. Towards the end of the meal another staff member came to take over yet there was no conversation with the person to explain why and the staff member made no attempt to engage with the person.

We met with the chef who had a good understanding and knowledge of people's dietary requirements and a record of these was kept in the kitchen. The chef knew which people were nutritionally at risk and showed us a 'low weight alert' list which was updated weekly and showed who required fortified meals and additional snacks. The chef described how they fortified meals with butter and cream to provide additional calories and did home baking of cakes, pastries and soups. Menus followed a four week rota and were changed seasonally and showed a variety of foods with a choice at each meal. We saw details of the menus were displayed in the home in words and pictures. We saw a food hygiene inspection had been carried out in May 2015 and the kitchen had been awarded four stars (five stars is the highest score that can be achieved).

The registered manager told us all new staff completed induction training and always shadowed a more experienced member of staff until they felt confident and competent to carry out their roles effectively and unsupervised. On the second day of the inspection we spoke with three recently employed staff who confirmed the induction training programme was thorough and informative.

Requires improvement

Is the service effective?

The registered manager confirmed that following induction training all new staff completed a programme of mandatory training which covered topics such as moving and handling, infection control, food hygiene, health and safety and safe guarding. We looked at the training matrix and saw mandatory training had been completed by staff within the recommended time frames for each training course. We saw additional training was provided on specialist topics such as pressure area care and dementia care.

On Greenholme unit we saw the nursing staff were working in partnership with Bradford University to develop specific training for staff caring for people living with dementia. We spoke with the nurse co-ordinating the project who told us the aim was to heighten staff awareness of the needs of people living with dementia and ensure people received person centred care.

The registered manager told us individual staff training and personal development needs were identified during their formal one to one supervision meetings with their line manager and their annual appraisal. Staff we spoke with confirmed they received supervision.

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). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw one person who used the service was subject to an authorised DoLS. We were told a further eleven applications had been made to the Supervisory Body for authorisation but with no outcome as yet.

We saw staff explained what they were proposing to do and gained consent from people before undertaking any task or activity. This showed us staff gained people's consent appropriately before delivering care.

People had access to healthcare services and this was reflected in the care records we reviewed. We saw people had been seen by the optician, chiropodist, GP, community matron and dieticians. This showed staff responded appropriately by seeking specialist advice to ensure people's healthcare needs were met. We spoke with two healthcare professionals who were visiting the home during our inspection. They told us they visited the home weekly and found staff acted upon the advice they gave. They both said there were some very good nurses working at the home.

Good

Is the service caring?

Our findings

People we spoke with were complimentary about the care they received and praised the staff. One person said, "Staff are extremely kind. I am well cared for, no doubt about that." Another person said, "I'd give it high marks. The staff here are very, very good. They work well and are always considerate even when they're working under pressure." Another person told us, "Staff are wonderful. They work very hard." A further person said, "The nurses are very good and although they're short staffed the staff here are excellent – very caring."

A relative said, "This is a wonderful place and the care staff are fantastic." Another relative told us, "(My family member) has been very well looked after. The care and staff have been superb."

One person told us about a staff member who had offered to take them out on their day off. They described how this meant they had been able to go home for the day and how much this had meant to them. They said, "It was such a nice thing to do. I didn't ask, (the staff member) just suggested it. It was over and above you know, going that extra mile for me."

We saw people were clean, well groomed and comfortably dressed. Staff were caring and patient in their approach and had a good rapport with people. Staff supported people in a calm and relaxed manner. They stopped to chat with people and listened, answered questions and showed interest in what they were saying. We observed staff initiating conversations with people in a friendly, sociable manner.

We found staff knew people well, they responded to people's requests and offered them choices. Staff knew what people were able to do for themselves and supported them to remain independent. We saw staff addressed people by their preferred name and always asked for their consent when they offered support or help with personal care. We saw staff knocking on doors before entering rooms, even when doors were open, and saying hello as they walked in.

We saw people's rooms were personalised and one person said, "It's nice having my own things around, makes it more homely." Communal areas were comfortable with clusters of seating areas so people could relax in small groups and talk with one another.

The registered manager told us no one who used the service required an advocate. However, they confirmed they would assist people to gain access to an independent advocacy service if it was required. We saw people's personal information was treated confidentially and their personal records were stored securely.

Requires improvement

Is the service responsive?

Our findings

People we spoke with expressed satisfaction with the care they received. However, we found the way care was planned and delivered was not always responsive to people's needs or person-centred. For example, because the hostess was not allowed to add thickener to people's drinks, they told us they left the drinks in people's rooms but out of their reach so care staff could add the thickener before giving them. This meant people could see their drinks but not have them until care staff were available and we saw one person shouting and trying to reach their drink.

We saw another person had not been supplied with the correct continence products which meant they were calling out in pain when staff tried to change them. This had not been identified or addressed by staff until it was raised by the person's relative. We looked at this person's care plan for continence and found it had not been updated since June 2015.

Another person's care records showed they required daily care to their hand to prevent pressure damage. The care plan directed staff to ensure the person had adequate pain relief before washing or soaking their hand and showed there had been a wound in the palm on 6 October 2015 yet there was no detail of what to apply to the wound. The last review on 4 November 2015 stated the skin was intact. Care staff told us they had to provide this care and described how they found this distressing as the person would scream when they tried to touch their hand and became very agitated when they were delivering any personal care. We witnessed this during our inspection. Care staff told us when they cleaned the hand it was often bleeding and said they reported this to the nurses. This was not reflected in the care records we reviewed and not mentioned by the nurses we spoke with who told us the skin on the person's palm was intact. We looked at this person's medication administration chart and saw they were prescribed a medicine used for agitation and one for pain yet neither had been given in the last three weeks. When we asked one of the nurses about this they said they did not give the medication as it made the person sleepy. When we asked if they had requested a medication review they said no and could provide no explanation why. We raised these issues with the registered manager and made a safeguarding referral in relation to this person.

We found care records did not accurately reflect people's care needs or show action taken to address risks identified in assessments. For example, one person had a surgical wound which had been reviewed on 13 October 2015 and was due for a further review on 20 October 2015 but there was nothing in the records to show this review had happened. When we asked the nurse they said they did not know. An assessment identified the person was at risk of pressure damage but there was no care plan in place for the prevention of pressure ulcers. This was a breach of the Regulation 9 (1) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On Greenholme unit the nurse told us they were in the process of reviewing all the care plans to ensure they provided good background information and life histories as this would enable staff to provide more person centred care. We saw where specific needs had been identified risk assessments were in place and provided information about how best to support the person including how to meet people's mobility, personal care and dietary needs. We saw the pre-admission assessment used by the service showed family members had been involved in the assessment process. The assessment identified how the person liked to be addressed; identified their needs and what was important to them.

The complaints procedure was displayed in the home. We looked at the complaints log and saw there had been four complaints since the last inspection. Records for three of these complaints showed they had been investigated and the outcome of the complaint had been communicated to the complainant. For one of the complaints there were no records; however the registered manager located these on the second day.

Some people we spoke with told us they knew how to make a complaint, but when we asked one person who they would go to they said, "I don't know really. I don't see the manager so I think it would be one of the staff."

One relative we spoke with told us they felt issues they raised were not listened to by the management or dealt with satisfactorily. Other relatives we spoke with said they felt they would be able to raise issues with the management and that they would be addressed.

However, we found staff were not always recognising or responding appropriately to complaints. We overheard a relative discussing concerns about their family member's

Requires improvement

Is the service responsive?

care with one of the nurses. The response the nurse gave to the relative was not appropriate and they did not take any action to address the issue the relative had raised or pass this on to the manager until we intervened. In another instance, a person told us of concerns they had reported about some of the night agency staff who they described as 'not knowing the meaning of the word care', yet the registered manager told us they were not aware of these concerns. This was a breach of the Regulation 16 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home employed two part time activities co-ordinators and a weekly list of activities was on display on both units.

The activities list showed a varied schedule which included arts and crafts, poetry reading, board games and listening to music. The activities co-ordinator told us they also encouraged people to participate in activities in the local community. They told us if people did not want to join in group activities they engaged with them on a one to one basis to ensure they did not become socially isolated. One person told us, "There's plenty going on if you want to join in." The activities organiser also told us they were working closely with the nursing staff on Greenholme unit to develop more meaningful activities for people living with dementia.

Inadequate

Is the service well-led?

Our findings

There was a clear management and staffing structure in the home. We saw the registered manager met with nursing staff and the head of each department every morning and shared information about all aspects of the service. Nursing care was overseen by a clinical service manager and the registered nurses were supported by a team of senior carers and care staff.

The registered manager has been in post for many years and most people we spoke with knew her. Relatives also knew the registered manager and some commented upon the leadership and management of the home. One relative said they found the registered manager was approachable and would not hesitate to ring her if they had any problems. Another relative said the registered manager was excellent, 'always listened' and described them as 'very approachable'. Another relative said they felt the registered manager was not approachable, did not listen and was rarely seen in the home as they were always in the office.

Feedback from staff was mixed. Some staff told us they felt issues they raised with the registered manager were ignored and not addressed and they had concerns about confidentiality. Staff told us they had repeatedly raised concerns about staffing levels but felt these were not listened to by the registered manager or senior managers. Staff told us about incidents that had occurred in the home which they felt had not been dealt with by the registered manager. Other staff we spoke with said they had confidence in the registered manager and felt they could go to her with concerns.

We found communication between care staff, nurses and the registered manager was not always effective. For example, staff told us of incidents that had been reported, yet when we discussed these with the registered manager they told us they were not aware of them.

We found the service had a variety of quality assurance systems in place however we found these were not effective in identifying shortfalls in the service provision and risks to people's health, safety and welfare. For example, we looked at the medicines audit completed on 2 November 2015 which reviewed four people's medicines and identified no shortfalls, yet our inspection found several issues. We saw care plan audits which had been completed by the registered manager and clinical service manager. These identified any shortfalls which were passed to the nurse to address, the registered manager told us either they or the clinical services manager then checked the care plans to ensure improvements had been made. However, there was no documentary evidence to show this had happened without reviewing each individual care plan.

We found there was no system in place to analyse accidents and incidents. When we asked the registered manager they said they checked individual reports for themes and trends but were unable to show us any records to evidence this. When we visited on the second day the manager showed us a falls analysis toolkit which they said they were going to start using. We looked at the accident and incident reports for October and found there were 25 in total, 18 of these were on Wharfedale unit and nine related to one person. Amongst these were two incidents that should have been referred to safeguarding and notified to CQC, which related to unexplained bruising. We found two incidents where people had fallen and it was recorded the nurses had suspected possible fractures yet they had contacted the GP to ask for advice rather than contacting the emergency services to taken the person to hospital. This meant there was a delay in people having access to appropriate medical care and treatment. We concluded there was no system in place to look at the overall risks to people who used the service, identify themes or consider 'lessons learnt' to reduce the likelihood of re-occurrences.

We looked at the last provider visit report completed on 13 October 2015 which identified several areas for improvement. The action plan listed 26 actions with all but two to be completed by 31 October 2015; only four had been signed off as done. The report did not identify many of the issues we identified during our inspection. This was a breach of the Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us a selection of people who used the service and relatives were asked to participate in an annual customer satisfaction survey. They confirmed the information provided was collated and an action plan formulated to address any concerns raised and information was shared with people who used the service, relatives and staff. However, the registered manager told us surveys were

Inadequate

Is the service well-led?

not sent to relatives or people living in Greenholme unit, which meant their views were not sought. The registered manager told us the service did not send out stakeholder survey questionnaires.

The registered manager told us an annual staff survey was carried out to seek their views and opinions of the service and to establish the level of engagement they have with the organisation. We also saw the organisation offered incentives to staff such as long service awards to thank them for their commitment.

We saw both staff and residents meetings were held so that people were kept informed of any changes to work practices or anything which might affect the day to day management of the service.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Service users were not protected from abuse and improper treatment as systems and processes were not established and operated effectively to investigate any allegation or evidence of abuse. Regulation 13 (2) & (3).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **An accessible system was not established or operated for identifying, receiving, recording, handling and responding to complaints. Regulation 16 (1) (2)**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed. Regulation 18 (1)

The enforcement action we took:
Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of service users was not appropriate and did not meet their needs or reflect their preferences. Regulation 9 (1) (a) (b) (c) (3) (b) (I)

The enforcement action we took:
Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not established or operated effectively to assess, monitor and improve the quality of the services provided or to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Regulation 17 (1) (2) (a) (b)

The enforcement action we took:
Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Enforcement actions

Treatment of disease, disorder or injury

Service users were not provided with care and treatment in a safe way in relation to the proper and safe management of medicines.

Regulation 12 (1) (2) (g)

The enforcement action we took:
Warning notice