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# Snydale Care Home

## Inspection report

Snydale Care Home
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Date of inspection visit:
16 May 2017
18 May 2017

Date of publication:
28 June 2017

## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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|---|---|
| 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? | **Requires Improvement** |

# Summary of findings

## Overall summary

This inspection took place on 16 and 18 May 2017. Day one was unannounced and day two was announced. At the last inspection in January 2016 we found the provider was in breach of five regulations and the service was rated as requires improvement. The regulations related to safeguarding people from abuse and improper treatment, staffing arrangements, dignity and respect, consent to care and governance. At this inspection we found the provider had taken action relating to the previous breaches but were in breach of two different regulations which related to person centred care and safe care and treatment.

Snydale Care Home provides accommodation and personal care for up to 52 older people. At the time of the inspection the service did not have a registered manager. A manager had been appointed and told us they would be submitting an application to be registered. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

At this inspection we found medicines were not being managed safely. People did not always receive their medicines as prescribed. Staffing arrangements had improved; people told us and we observed there were enough staff to meet people's needs. People lived in a safe environment and most areas of the home were well decorated. A problem was identified with the temperature of one shower; swift action was taken to rectify this. Risks to people were assessed, however they were not always appropriately managed; this meant people were not always safe because action was not taken to reduce risk.

Staff told us they felt well supported and had received training to help them understand how to do their job although some struggled to recall what they had learnt. People were encouraged to make their own decisions. Systems were in place to ensure people were protected when they were deprived of their liberty. People enjoyed the food and received choice and varied meals. They told us their health needs were met but it was difficult to find out when people received support from healthcare professionals because appointments were not consistently recorded. We have made a recommendation about oral healthcare

People told us they were well cared for and staff were kind. Visiting relatives told us they were always made welcome and the service was caring. On both days of the inspection we saw people were treated with kindness and respect. There was a pleasant and relaxed atmosphere. People looked well cared for and were comfortable in their environment. They could choose where to spend their time. Communal areas provided adequate space for people to watch television, spend time with a group or in a quieter area.

We received mixed feedback when people told us about their experience of moving into the service. One person told us it was a positive experience; two people told us they did not receive an introduction so did not know what to expect. The quality of care recording and care planning varied. Some information was personalised; other information was out of date and there was a lack of guidance. People enjoyed the range of activities provided in the service and the local community. People were comfortable raising concerns and

complaints.

People who used the service, their relatives and staff told us the service was well led. The management team encouraged everyone to share their views through meetings and surveys. The provider had systems in place to monitor different areas of the service; however, auditing processes had not picked up issues identified at the inspection.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. These related to safe care and treatment and person centred care. You can see the action we have told the provider to take at the end of this report.

## 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.

Medicines were not managed safely. There was insufficient guidance for staff to understand how to administer medicines safely and people did not always get their medicines as prescribed.

Systems were in place to identify risk but once identified these were not reduced because the management of risk was not effective.

There were enough staff to meet people's needs.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Systems for assisting people to make decisions in line with the requirements of the MCA had improved.

Staff felt well supported in their role although some were lacking in knowledge even though they had received training.

People told us their health needs were met but health appointments were not consistently recorded.

### Is the service caring?

**Good**

The service was caring.

People who used the service and visitors we spoke with were complimentary about staff and told us the service was caring.

Staff were observed to be caring and kind in their interactions with people. They knew the people they supported.

There was information displayed around the service which helped to keep people informed.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive.

The provider's care planning system was not always person centred and guidance for staff about delivering care was varied.

People enjoyed a range of activities within the service and the local community.

People were comfortable raising concerns. A system was in place to record and respond to complaints.

## Is the service well-led?

**Requires Improvement**

The service was not always well led.

At the last inspection we rated the service as requires improvement and found multiple breaches. At this inspection we rated the service as requires improvement again and found two breaches.

People told us the service was well led. Staff told us they enjoyed working at the service.

The provider has systems in place to check systems were working effectively. These identified areas to develop and improve; however, they were not always effective because they had failed to pick up key issues with medicines, risk management and care planning.

# Snydale Care Home

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 16 and 18 May 2017. Day one was unannounced. Day two was announced because we wanted to make sure the manager and area manager could attend the feedback session. Two adult social care inspectors and two experts-by-experience carried out the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed all the information we held about the service including statutory notifications. We contacted the local clinical commissioning group, fire service, Healthwatch, the local contracting and safeguarding authority. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We often ask providers to complete a Provider Information Return (PIR), however on this occasion we did not request one. It is a form that asks the provider to give some key information about the service. We gathered some of the key information during the inspection.

At the time of our inspection there were 35 people using the service. During our visit we spoke with 12 people who used the service, nine visiting relatives, two health professionals, ten members of staff, the manager and director of care. In the report we have made reference to the management team; this relates to the manager and director of care who visited the service on a regular basis. During the inspection we observed how people were being cared for and looked around areas of the home, which included some people's bedrooms and communal rooms. We spent time looking at documents and records that related to people's care and the management of the home. We looked at eight people's care records.

Inadequate

# Is the service safe?

## Our findings

At the last inspection we found the provider was not safeguarding people from unlawful restraint and they did not always have enough staff to meet people's needs in a timely way. At this inspection we found people were not being unlawfully restrained and improvements had been made around the staffing arrangements. However, when we looked at management of risk and medicines we found this was not done safely.

We saw people's needs were assessed to find out if people were at risk. The assessments covered areas such as risk of choking, pressure sores, malnutrition and use of bed rails. These were reviewed on a regular bass and the level of risk was identified, for example, low risk or high risk.

Although risks were identified we found robust systems were not in place to manage some of those risks. We saw two people were at risk of malnutrition and had lost weight; they were not receiving appropriate support to manage their weight loss. At the beginning of April 2017, a GP had provided advice, relating to one person, to 'continue weekly weights, custard shots and food and fluid monitoring charts'. We saw none of this advice was being followed. Custard shots are high in calorie and help people gain weight. When we reviewed the care records on day one of the inspection we saw the person was only weighed three times in 2017; once in January, once in February and once in April. Each weight record showed the person had lost weight. The food and fluid charts showed they were not receiving regular custard shots and the fluid intake was not meeting the recommended intake for the person. When we returned on day two the director of care said they had found some additional weight charts which showed the person had recently gained weight.

Another person had been losing weight since starting to use the service in October 2016. In the first month they lived at Snydale Care Home they lost an amount equivalent to over 20% of their body weight. There was no evidence of any referral to a dietician or other health professional when this was identified. We saw from the person's care plan they were supposed to be weighed weekly. This was not being done. A referral to a dietician was made in May 2017, at which point the person had lost over 30% of their body weight. We asked the manager and director of care if there was any evidence the service had responded to this risk before the referral to the dietician. They were unable to provide any.

We visited one person who was in bed in their room. We noted they had a bed rail in place to prevent them from falling out. The use of bed rails had been assessed, however, there was no bumper covering the bed rail so gaps that could cause entrapment of neck, head and chest were not eliminated. Therefore the risk was not appropriately managed.

We saw one person had developed a pressure sore. The person was assessed as 'high risk' however, their care plan did not reflect the care that should be delivered. The district nursing team advised the day before the inspection that the person could get up for short periods during the day but the care plan had not been updated and staff were unaware. We asked three care workers and a senior care worker about care delivery and they told us the person had to be nursed in bed. When we returned on day two of the inspection we saw steps had been taken to make sure staff were fully aware of the changes.

Before the inspection the provider had notified us about a safeguarding incident which involved two people who used the service. They had liaised with other local agencies and put measures in place to prevent a repeat event which included regular checks to make sure the people involved were safe. At the inspection we reviewed the records and saw staff were not recording the checks consistently. We also saw the people were together during the morning but this had not been captured on the check list. When we returned on day two of the inspection we saw steps had been taken to make sure the measures put in place to prevent a repeat event were being implemented. We concluded the registered person was not doing all that is reasonably practicable to mitigate risks.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

People we spoke with told us they always received their medicines at the same time. One person said, "The staff give me my tablets early in the morning when I get up. That's my choice." A visiting relative said, "I come nearly every day. I always see [name of relative] getting her medication on time." However, when we checked medication records and stock balance we found people were not getting their medicines as prescribed.

Instructions for medicines did not always correspond. We saw that sometimes the medication administration record (MAR) instruction did not match the medicine label. For example, one person's MAR stated they should receive a medicine three times a day, a stock record stated they should receive the medicine once daily and the medicine container stated to take 'as directed'. Two people were prescribed medicine which should be taken 30- 60 minutes before breakfast when the stomach is empty. However, these instructions were not recorded on the dosette box or the MARs. Staff confirmed the medicines were given with breakfast. Not administering medicines as directed by the prescriber increases the risk of the medicine not working as intended.

The provider did not have an effective system for checking the stock of medicines was correct. We counted four people's medicine stock and found the balance for all four was incorrect. One person's stock balance sheet stated they had 30 sachets of Laxido which is used for constipation at the beginning of the medicine cycle. They should have received one sachet per day and the MAR had signatures to indicate 25 sachets were administered. The stock balance should have been five but 20 were in stock. Another person had an inhaler and 30 doses were in stock at the beginning of the cycle. They should have received one daily dose and the MAR had signatures to indicate 23 doses were administered. The stock balance should have been seven but 16 were in stock.

Some people were prescribed topical creams and pain relief patches. However, charts to record the application were not completed consistently. MARs were completed when pain relief patches were applied but body charts were not used. This meant people were at the risk of harm from duplicate application because staff might not know where patches had been previously applied. Body maps and topical MARs were not completed consistently when creams were applied. We saw care workers were sometimes responsible for applying cream and senior staff signed the MAR, however they did not have a system to check the application was carried out.

Two people with swallowing problems were prescribed thickener which was used to thicken fluids. We found staff did not always record when this was used. We saw the thickener was sometimes left on the tea trolley so was not stored safely. We also saw that the thickener was not used for the person it was prescribed. Staff told us one person had recently been prescribed thickener and this had been added to their drinks; we saw entries in their care records which confirmed this. However, when we checked their

stock of thickener we saw this was unopened so concluded they had been given thickener prescribed for someone else.

Medicines were stored securely in a locked treatment room and access was restricted to authorised staff. There were appropriate arrangements in place for the management of controlled drugs. They were stored in a controlled drugs cupboard and staff regularly carried out balance checks of controlled drugs. Although we saw staff carried out regular checks we noted that one person's stock was incorrectly recorded. We established the stock was correct but a member of staff had made an incorrect entry on the register which had not been picked up. Controlled drugs are medicines that require extra checks and special storage because of their potential for misuse.

People had been prescribed 'as required' medicine, for example, painkillers, but not everyone had guidance about how and when their medicine should be administered. For example, one person was prescribed a medicine used to treat anxiety; there was no guidance for staff to know when this should be administered. Another person was prescribed a pain relief gel; there was no guidance for staff to know where and when to apply. We concluded the registered person was not managing medicines safely.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

People told us they felt safe living at Snydale Care Home. One person said, "They (staff) come round to see you to make sure you're safe (at night) and to make sure you don't fall out of bed."
Another person said, "Yes, I do feel safe. I don't worry at all." A relative said, "I am absolutely sure that my wife is safe here." Another relative said, "Everything is smashing here. The staff always say hello to him in his room. This makes him feel so secure."

On day one of the inspection one person told us they were concerned because another person who used the service came into their room and this made them anxious. When we returned on day two we checked the person's notes and saw they had been upset in the early hours of the morning because someone had entered their room. We raised this concern with the manager who agreed to follow it up. After the inspection the manager contacted us and said they had put measures in place to make sure the risk of repeat events had been reduced.

Staff we spoke with said they had attended safeguarding training and records we reviewed confirmed this. Staff told us they were confident if safeguarding concerns were raised the management team would deal with any issues appropriately and promptly. Some staff were unsure where they would report any safeguarding concerns outside of the organisation but said they would be able to find out. Information about reporting whistleblowing concerns was displayed in the home, however there was no information about how to contact the local authority who is responsible for making sure systems are in place to prevent abuse and neglect. Whistle blowing is when an employee raises a concern about a wrong doing within an organisation.

We carried out a tour of the building and saw most areas of the home were well decorated; some bedrooms were being painted. Framed pictures were hung in corridors and communal areas to help create a homely environment. The service had a shower room and two bathrooms. The shower room which was situated on the ground floor was being used to store furniture so was not a pleasant area for people to shower. The temperature of the water was very hot; it reached 50 C and an inspector who tested the water could not hold their hand under the water flow. We brought this to the attention of the area manager who said they would make sure this was addressed immediately. Two bathrooms were on the first floor. One had overhead

tracking so people could be hoisted into the bath. The other bathroom had a bath chair. We saw this bathroom was dirty. There was dirt and dust in places, and thick grime around the bath seat stand. It was evident the room had not been deep cleaned for some time. The member of staff who showed us around the service arranged for the bathroom to be deep cleaned straightway. The room also had surfaces which were not easy to clean because paint was flaky and there were gaps where pipework was boxed in. We also noted a toilet downstairs had a large crack around the base. The director of care said these areas were due to be refurbished.

Throughout the service we saw personal protective equipment such as gloves and aprons, alcohol hand gel, liquid soap and paper towels was available, and staff were observed using it appropriately.

Some people spent time in their room. They told us staff checked to make sure they were safe and could use their call bell is they needed assistance. We saw staff had placed call bell leads within easy reach.

People and visiting relatives we spoke with told us staff were always available to assist them during the day and the night. Comments included, "I would say the staffing is the best it's ever been; it went down last year", "I've used the buzzer, oh yes, they're quick", "It always seems well-staffed" and "It seems to me that sometimes there are not enough staff or perhaps it is just at busy times". One person said they sometimes had to wait for staff.

On both days of the inspection we saw staff had time to meet people's care and support needs, without rushing. For example, we saw one member of staff helping people move from the lounge through to the dining room. Staff took the time to support people patiently, chatting as they helped people, enabling them to walk wherever possible or supporting with equipment, such as, wheelchairs. Call bells were answered swiftly.

The director of care told us they did not use a dependency tool to calculate staffing levels but instead had regular meetings to discuss this with the manager. They told us they considered factors such as occupancy levels, the needs of people using the service, a review of accidents and incidents, whether anyone was receiving end of life care and feedback from staff. They told us these meetings were held weekly, with additional reviews when anyone new began using the service.

We spoke with staff who had recently been recruited. They told us they had gone through a robust recruitment process and could not start work until all the relevant checks were completed. Records we reviewed confirmed this.

Requires Improvement

# Is the service effective?

## Our findings

At the last inspection we found the provider was not meeting the requirements of the Mental Capacity Act 2005 (MCA) because consent to care was not always sought. At this inspection we found systems had improved sufficient to meet regulation however they still needed to develop these further to ensure the service was consistently effectively.

The 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 so that they can 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 Deprivation of Liberty Safeguards (DoLS).

The manager and staff we spoke with had a clear understanding of who had an authorised DoLS and who had a submitted DoLS and was waiting for an outcome. The manager said they ensured applications were submitted when DoLS were due to expire. Records we reviewed confirmed this. One person had a condition attached to their DoLS which stated they must have regular reviews. The manager was fully aware of the condition and ensured this was adhered to.

We looked at records where people had given consent to care and people's capacity to take decisions was considered, and found these varied in quality. We saw examples where 'best interest decisions' were recorded and other professionals or appropriate others were involved. One person's care file contained evidence that a relative could make decisions on their behalf, and it was evident they had been involved. They had been involved in making decisions around receiving 24 hour care and the use of bed rails. Consent and care plan documentation had been signed.

However, we reviewed some care records and found consent documents were not always signed or signed by the appropriate person. For example, one care plan we looked at contained a signed consent for photography, however the consent form for the use of bedrails was only signed by a member of staff. Another care plan contained consent to photography and was signed by a relative, however the person's 'cognition and capacity' care plan stated they had fully capacity to make decisions. This meant they should have signed their own consent form. The management team had completed care plan audits; we saw from the audits they had highlighted shortfalls with consent documentation and had set timescales when these had to be completed.

Staff we spoke with were very confident that where possible people made their own decisions. One member of staff said, "Everyone has capacity to some extent. Even if they can't make the bigger decisions we still support them to make everyday choices such as what to wear, when to get up and what to eat and drink." Another member of staff said, "I think we are very good at asking people what they want. I see it every day." Staff also understood that some people did not have capacity to make certain decisions although some staff

were unclear what these measures were, for example, assessing a person's capacity around specific decisions and 'best interest decisions'. Some staff said they had completed MCA training where as others said they had not or could not remember the content. Staff who were not confident around MCA said they would seek guidance from a member of the management team or a senior member of staff.

People we spoke with told us staff had the right skills and knew how to look after them properly. One person said, "They're skilled enough to do what we need." Another person said, "I think they're pretty well trained."

We looked at the records relating to training provided for staff. We saw this included moving and handling, safeguarding, infection control, mental capacity and DoLS and pressure care. In addition we saw medicines training was undertaken by those with responsibility for this area of people's care and support. We saw there were some gaps where staff had not received annual refresher training in some areas. For example, six staff had not had updates to their moving and handling training for over a year, and 14 staff had not received their annual refresher training in mental capacity and DoLS. The management team said plans were in place to complete any refresher training that was overdue.

Staff we spoke with said they had received appropriate supervision and training although some struggled to recall some of the training sessions they attended and what they had learnt. One member of staff said, "I believe my training and experience gives me the confidence to support people with their individual needs." Another member of staff said, ".I have had safeguarding training, but I can't remember who it is I contact if I have any concerns about people." One member of staff said they had not completed safeguarding, MCA or moving and handling training. When we showed them the training record which confirmed their attendance they said they had completed the training but could not remember what it covered.

The director of care told us care staff should have a minimum of six supervisions per year and an annual appraisal. We saw staff received regular supervision, however this did not tend to include discussion. Staff received and signed for information sheets relating to their role and covered topics such as safe use of sharps or good moving and handling practice. We saw evidence of meaningful discussion taking place which included performance, training needs and concerns during staff's annual appraisal. They checked whether actions identified at the last appraisal had been completed. Staff were asked to give feedback on the leadership in the service and make suggestions for service improvement. We discussed the lack of staff knowledge in some key areas; the management team said they would review their supervision arrangements and incorporate learning from training.

We observed breakfast and lunch which was a pleasant experience. People told us they had a choice at meal times and were happy with the quality of food served. We saw people were informed what was on the menu in advance of their daily meals and offered choice and support at meal times. One person said they didn't know what to have at breakfast. A member of staff went through all the options and told them they usually had a bowl of cereal and an egg sandwich. The person decided to have their usual breakfast and clearly enjoyed it. When people finished their meal staff checked if they had enough to eat and if they had enjoyed it.

Most people ate in the dining room although some chose to eat in the lounge or their room. People were offered the choice of wearing a clothes protector. Napkins were given to people after the meal rather than before. At lunch there was not much room; tables were close together. If anyone else chose to eat in the dining room they could not have been accommodated. Meals were served from the kitchen via a serving hatch.

The food looked appetising and we saw people enjoyed it. At breakfast people were offered cereals,

porridge, toast, eggs and bacon. The lunch meal options were beef lasagne or fish in cheese sauce, served with mashed potatoes and vegetables. For dessert people had sticky toffee pudding and custard. People's comments included, "The food's good. If you don't like what's on, you just tell them", "The foods ok. I've no complaints" and "We have plenty to eat. The food is always nice". A visiting relative said, "The cook will cook anything within reason." Another visitor said, "Nothing is too much trouble for the staff in the kitchen."

The cook explained menus were being further developed to make sure the meals reflected what people liked to eat. We saw the menu for the day was displayed near the entrance of the dining room; the cook said they had ordered menu stands and once they had agreed the menus these would available on each table and large menus would be laminated and displayed.

People told us their health needs were met. They told us the GP, district nurses and chiropodist visited on a regular basis. One person said, "The chiropodist comes every now and then and I've seen the doctor." Another person said, "I have my own dentist and optician. The staff make me an appointment when the time comes around." Another person said, "My foot was bad. I'd got a lump on it and they got the doctor straight away. I see a foot nurse regularly."

People had a separate record of contact with health professionals, however, these were not consistently completed so it was not possible to get an overview of when people had received healthcare and treatment. We saw from the health professional visit records there was regular contact with GPs and district nurses. Chiropodist and optician appointments were often recorded on a central record and not on an individual basis. We also saw specialist health care appointments were sometimes recorded in people's daily notes and not on the health professional visit record so it was difficult locating when they last attended some appointments. The management team said they had identified care recording was not consistent and were planning additional training to ensure staff fully understood the care planning and recording process.

The director of care said they had not been able to arrange dental appointments for people because they had not been able to find a dental service who would visit. They said they managed this by ensuring anyone who expressed dental problems accessed community services. We saw two recent examples where this had happened. People did not have oral health assessments or oral health care plans which would help identify and prevent problems. We recommend that the service consider current guidance around oral health for adults in care homes.

Good

# Is the service caring?

## Our findings

People told us they were well cared for and staff were kind. Comments included. "They are a smashing bunch", "They're lovely. They always talk to us and can't do enough for us", "They help you as much as they can", "They care for me with respect and dignity", "We joke and have a laugh together. They're all lovely", "It is home from home here", "They've all been kind to me here", "I get on with everybody. The staff are great", "Everyone is so friendly and kind" and "I get on with all the staff. They are like family". People said they could make decisions although some said they chose not to. For example, one person said, "I'm getting lazy now and don't want to be bothered. They look after me well though."

Visiting relatives told us they were always made welcome and the service was caring. Comments included, "The staff are very friendly and I visit whenever I like", "I appreciate everything they do for her", "I regard the staff as friends", "I just cannot thank the staff enough for their care and understanding", "The staff are such lovely people", "We are confident that all mum's needs are met", "The staff offer such care and consideration". One relative described the service as 'the best' and thought they had improved over the last few months. A visiting professional told us, "This is a lovely environment. All the staff are friendly, caring and respectful."

On both days of the inspection we saw people were treated with kindness and respect. There was a pleasant and relaxed atmosphere. We saw there was lots of laughter as people enjoyed banter with staff. Staff knew people well and they were friendly and chatted to people as they passed. We saw examples where staff were attentive and noted people needed additional support. For example, one person was anxious. We saw a staff member providing comfort to the person in a warm and caring way as they did this, the person's body and facial expressions showed they were relaxed and comforted.

People were comfortable in their environment and could choose where to spend their time. Communal areas provided adequate space for people to watch television, spend time with a group or in a quieter area. People could access areas when they wanted privacy for example, if they wanted to be alone or had visitors. Staff respected people's privacy by knocking on doors and calling out before they entered their bedroom or toilet areas.

We saw people looked well presented, with hair styled and pressed, clean clothes. The hairdresser visited once a week. One person told us they loved having their hair done because it made them feel 'much better'.

When we looked around the service we saw there was information displayed around the service which helped to keep people informed. Activities and menus were displayed and these were updated when options changed. There were notices and leaflets around advocacy, Healthwatch and how to get help and support, and how to make a complaint. A care aware helpline was provided. The provider displayed information about the previous inspection near the entrance of the service.

Requires Improvement

# Is the service responsive?

## Our findings

At the last inspection we found care records were not kept in a secure cupboard and there was a risk people could access sensitive information. At this inspection we saw care files were kept secure and staff returned care records once they had written and reviewed them.

Just before the inspection four people had moved into the service; two had moved in the day before and two people moved in five days before. We reviewed two people's pre admission assessments and initial care plans. These showed the provider had identified potential risks and gathered important information to make sure staff knew what was important to the person and how to provide care. The manager told us they would be reviewing the initial assessments and care plans after four weeks.

We spoke with three people who had moved into the service in the days before the inspection. Two people told us they were settling in well although two told us they had not had an introduction and no-one had explained what to expect at the home. One person said they were very worried about going to their room because they did not know how to ask for help. We asked staff to go through the call bell system which they did; the person said they felt much better after staff had spoken with them. One person told us they had a positive experience when they had moved in and told us, "They really get to know you. They come and talk to you when you first come in and find out what your likes and dislikes are. I have a booklet called 'All about me'. It tells new staff what I need." A visiting relative told us they had been asked to provide information before their relative moved in and said the move was well organised. However, they had been disappointed because information about assistance with meals had not been passed on initially.

People had life story books within their care files and an additional sheet within their rooms called all about me. These contained information about their 'childhood', 'adulthood', and 'current information'. We saw people's relatives had been asked to contribute to the books so as much detail as possible could be added; this helps staff get to know the person and prompts areas of discussion. One person who had just moved into the service said they had been asked to fill in a booklet.

When we looked at care plans for people who had been staying at the service for a longer period we found they varied in quality. Some information was detailed and identified how staff should deliver care to meet the person's needs. However, we also found some information was not up to date or accurate.

Examples where care and support was set out so staff would understand how to meet people's needs included information in one person's care plan about how they chose their meals independently and how staff should communicate with them.

Examples where care and support was not set out in the written plan of care included out of date information and a lack of guidance. One person's plan contained information that was a year old and had been written on the day they moved into the service. It stated their 'speech was poor' and 'may improve over a period of time'. The last care plan review in April 2017 stated their 'speech continues to be poor'. The care plan contained no guidance around how the person communicated or how staff should support the person

to communicate. The person's care plan stated they were staying at the service for a respite stay but it was evident from discussions with staff they lived there on a permanent basis.

One person told us they were depressed and it was evident from discussions with the person and staff they were affected by mental ill health. We saw specialist mental health workers had visited the person and recommended approaches to help improve their mental health, however, when we reviewed the person's care plan and daily notes there was no reference to staff following the guidance. We reviewed two weeks daily notes and saw they contained very little information about the person's wellbeing even though staff told us they had regularly expressed negative thoughts.

Although people looked well presented, we noted one person had dirty fingernails. We asked to look at the person's bathing and showering records because there was no reference to this in their daily notes. The management team said communal records were maintained although they could not locate all of these. For example, a bathing record was located for week commencing 8 May 2017 but there was no record for the previous week. The director of care said they were working towards all information being recorded individually because communal records did not evidence a person centred approach.

We shared the findings around the care recording and planning process with the manager and director of care. They showed us audits that confirmed they had identified these areas needed to improve. They had recorded in an action plan that staff needed to receive training in care planning and the timescale for achieving this was the end of June 2017. We concluded people's care was not designed with a view to ensuring their needs were met.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred Care.

People told us they enjoyed the activity programme. Comments included, "I like it when they get entertainment in", "We raised money for Children in Need and Leeds Children's Hospital this year", "I like the dominoes and the bingo. We have such a laugh", "There is always plenty going off" and "I love anything that involves dancing".

We observed a 'daily chat' session and an arts and craft session on the first day of the inspection. On the second day we observed a daily chat and bingo session. The activity coordinator showed us the prompt for the daily chat sessions which covered historic and current stories and headlines, a daily poem, jokes, common phrases, and an activity such as a crossword.

The activity co-coordinator discussed the activity programme which they said varied each week. An external facilitator visited the service every Wednesday and offered people an exercise and aromatherapy session. Entertainment sessions were also provided. In June they were planning an Elvis tribute afternoon, Ascot Day, musical show and cake fayre. The week before the inspection two outings had taken place; one to the garden centre and another to the local public house. The service had a minibus which people accessed.

People and their relatives said they would speak to someone if they were worried or had any concerns. Comments included; "I always speak my mind and would say if anything was wrong",
"You can talk to the staff about anything and they sort it straightaway", "I could talk to the managers about anything", "I have complained in the past and the owners dealt with it straightaway" and "The management meet with us regularly and are always encouraging us to come to them if we have the smallest concern".

We looked at records of complaints and concerns received by the service. We saw there was a policy in place

and this was followed. Complaints and concerns were logged together with details of actions taken, the outcome and the date the issues were resolved. Copies of correspondence and any other investigations were also filed. We saw any issues raised were investigated thoroughly, and this included any concerns raised anonymously. We also saw complaints management was reviewed in the director of care's regular audits of the home.

Requires Improvement

# Is the service well-led?

## Our findings

At the last inspection we found the provider was in breach of five regulations and the service was rated as requires improvement. At this inspection we found the provider had taken action relating to the previous breaches but were in breach of two different regulations and therefore has been rated as requires improvement again.

At the time of the inspection there was not a registered manager; the previous registered manager stopped working at the service in January 2017. A new manager had been appointed and told us they would be submitting an application to be registered.

People who used the service and their relatives told us they would recommend Snydale Care Home to others. They said the service was well led although people were unsure who the manager was. Some people told us they had noticed the home had improved. Comments included, "The manager is very friendly.", "The manager does not seems as strong as the last manager", "She's been so helpful, throughout all the changes", "I'm quite happy with my environment. It's a good home to be in"; "All the senior staff and care staff are approachable. There is nothing that [name of manager] will not do for you." A relative said they did not know the manager very well but said "she is very nice".

People told us they had attended meetings where they had opportunities to share any suggestions and received feedback about what was happening. Some people said they had completed questionnaires; others said they had not. Relatives said they were encouraged to speak out at meetings and fill in questionnaires. We looked at survey results and saw the analysis was very positive, however, it did not include comments from one survey which were negative. We discussed this with the manager who said, "This was received after the analysis was done. We have not date stamped it so I can't say when it was received." We discussed whether any consideration had been given to updating the analysis to ensure this feedback was captured. The manager told us this had not been considered, but they would take this action if the same circumstances arose again in future.

We saw there was a programme of audits in place to help the provider measure, monitor and improve quality in the service. There was a clear schedule and we saw evidence the manager had followed this. Audits included accidents and incidents, medication, pressure sore care, dining room and nutrition, health and safety, mattresses and infection control. In addition we saw the director of care carried out a monthly audit visit which looked at a number of areas including, speaking with staff and residents about living and working at the home, complaints and compliments, premises, care files and medicines. We saw audits produced clear action plans showing improvements needed, who was responsible and the timescale for making improvement. We saw evidence these action plans were followed. Although the audit programme was comprehensive, we found audits relating to medicines and care plans were not always sufficiently robust. For example, errors with medication identified during this inspection were not picked up in the medication audit because it did not include checking stock balances. The director of care said they would review these audits to ensure they were effective.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The registered person was not designing care with a view to ensuring people's needs were met. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The registered person was not doing all that is reasonably practicable to mitigate risks.<br><br>The registered person was not managing medicines safely |