Handsale Limited

Handsale Limited - Bierley Court

Inspection report

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06 September 2017

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

Summary of findings

Overall summary

The inspection was carried out on 15 August and 6 September 2017 and was unannounced on both days.

Handsale Limited - Bierley Court provides accommodation and personal care to a maximum of 40 people. There were 34 people living at the home when we carried out our inspection. Most of these people were older people and people living with dementia.

The last inspection was in May 2016 and the service was rated good overall. There was one breach of regulation in relation to staffing, (Regulation 18). During this inspection we found the provider had not made the required improvements and they remained in breach of the regulation 18. We identified other concerns and three additional breaches of regulation. We found people were not experiencing good quality outcomes. The overall rating in now 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.

There was a registered manager but they had not been at the home since January 2017. They were working at another service operated by the provider. 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.

There was a new manager at Bierley Court but they were not registered with CQC at the time of our inspection.

People living at the home and relatives told us they felt the service was safe. We were concerned that people would not consistently receive safe and appropriate care because there were not always enough staff on duty.

The new manager had stared to make changes to the way staff were deployed which meant they could work anywhere in the home rather than being based on a particular unit. We found some people living in the home, relatives and staff were anxious about this change. In addition we found the change was not always supported by good communication systems which meant staff did not always have the information they needed to make sure people got the right care.

Accidents and incidents were recorded but it wasn't always possible to find out whether or not they had been investigated and if action had been taken to protect people from harm.

For the most part people received their medicines as prescribed. However, when errors had been identified it wasn't always possible to establish what action had been taken.

The home was clean but essential safety checks were not always carried out and staff had not all received fire training.

The required checks were done before new staff started work and this helped to ensure only staff suitable to work with vulnerable people were employed. New staff received induction training to help them carry out their roles. Staff received training to help them work safety. The provider had systems in place to check that the necessary training had been delivered but we found these were not always effective.

Most people told us they enjoyed the food and said they were offered a choice of food and drink. However, we were concerned people who were at risk of poor nutrition were not always receiving the right care and support.

We saw people had access to health care professionals but this was not always recorded and therefore it wasn't always possible to see how decisions about people's health care had been made.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. People were asked for their consent but this was not always recorded in their care records.

People told us staff were kind and caring and we saw a lot of good interactions between staff and people who lived at the home. For the most part people's privacy and dignity were respected. However, we were concerned people's dignity could be compromised because staff were too busy to provide support when it was needed.

People's needs were assessed. There were care plans in place but the plans did not always provide clear guidance for staff on how to support people.

People were not consistently provided with the support they needed to take part in social activities. Although there were three activities staff employed they were regularly required to carry out other duties such as caring or housekeeping. We recommended the provider review the arrangements for supporting people to take part in person-centred activities and encouraging people to maintain their hobbies and interests

People knew how to raise concerns or make a complaint. Complaints and concerns were not always recorded and therefore could not be monitored or analysed to look for trends and patterns.

There had been a lot of management changes and the provider's quality assurance and monitoring systems had not been operated effectively.

The provider had engaged the services of a consultant and new quality checks were being introduced.

There were meetings for people who used the service and people told us they felt they were listened to. The people we spoke with told us they would recommend the home.

We found the provider was in breach of four regulations; one of these was in relation to staff (Regulation 18) and was a continued breach from the last inspection in May 2016. The other breaches were in relation to safe care and treatment (Regulation 12), meeting people's nutritional needs (Regulation 14) and governance (Regulation 17). You can see what action we told the provider to take at the back of the full version of the 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.

Although people told us they felt safe we found there were not always enough staff deployed to make sure people received consistent and appropriate care.

Risks to people's health and welfare were not always managed appropriately.

Medicines were stored securely and the records were well completed. There were occasions when people did not receive their medicines as prescribed and although this had been reported it was not always clear what action had been taken.

The home was clean but essential safety checks were not always completed consistently.

Is the service effective?

Requires Improvement

The service was not always effective.

Most people told us they enjoyed the food and were offered choices. However, we were concerned people who were at risk of poor nutrition were not always receiving the right support.

People received support from a range of health care professionals but this was not always recorded properly.

The service was working in accordance with the Mental Capacity Act 2005 which helped to make sure people's rights were protected. People were asked for consent before care was delivered but this was not always reflected in their records.

Staff were trained to carry out their duties safely. Although the provider had systems in place to check that the necessary training had taken place these were not always effective.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us the staff were kind and caring. We saw staff were kind and treated people with kindness, warmth and compassion.

For the most part people's privacy and dignity were respected but sometimes this was compromised because staff were too busy to respond to people's requests in a timely way.

People felt they were listened to and able to raise issues.

Is the service responsive?

Requires Improvement

The service was not consistently responsive

People's needs were assessed. There were care plans in place but it wasn't always clear what staff needed to do to make sure people received the right support.

People were not consistently provided with opportunities to take part in social activities.

People knew how to raise concerns. Complaints and concerns were not always recorded.

Is the service well-led?

Inadequate

The service was not well led.

There had been a number of management changes and the providers quality assurance systems had not been operated effectively.

People were given the opportunity to share their views and everyone we spoke with said they would recommend the service.

Handsale Limited - Bierley Court

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 was carried out over two days, both were unannounced. The first inspection visit was on 15 August 2017 and the second took place on 6 September 2017.

On the first day the inspection team consisted of three adult social care inspectors. On the second day there were two adult social care inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case our expert was experienced in the care of older people and people living with dementia.

During the inspection we spoke with seven people who lived at the home and two people's relatives. We spoke with ten care workers, including senior care workers, the chef, the administrator, the registered manager, the new manager and a consultant supporting the management of the service.

We observed people being supported in the communal rooms and observed meal service at breakfast and lunch time. We looked at five people's care records and other records such as handover notes, medication records, meeting notes, accident and incident reports, complaints and maintenance records. We looked around the home.

Before visiting the home we reviewed the information we held about the service, this included notifications sent to us by the provider. We contacted the local authority commissioning and safeguarding teams to ask for their views of the service.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a document which gives the provider the opportunity to tell us about their service and any planned improvements. All this information was taken into consideration when we rated the service.

Inadequate

Is the service safe?

Our findings

People told us the staff looked after them well. One person said, "I think the staff are super good, they give me a lot of help, and look after me well."

However, while people were complimentary about individual staff members a number of people expressed concerns about staffing levels. One person told that because two staff were required to assist with their rota stand and they often had to wait a considerable amount of time for staff to be available. They said, "It is very nice and very friendly when we have enough staff, just now it's a bit of a jumble and it's upsetting because they are changing too much. I have to wait to go to the toilet sometimes if they are too busy, and I have to wet myself, then they change me."

Another person said, "I know the night staff, I like the staff. I like to have the same staff. I think the staff could do with a bit of help as they are always busy. Even though they are busy you don't wait long." A third person said, "If I need staff I buzz, I don't have to wait long. Sometimes they are busy so may take a little longer." A fourth person said, "The staff are very good but we are very short staffed and have been for a while now. Five staff have left and we are waiting for some new ones to get clearance to start."

Relatives we spoke with also had concerns, one relative said, "There are not really enough staff here." Another relative said, "The amount of staff is questionable, not always enough."

At the last inspection we found the provider was in breach of regulation because they did not have enough staff deployed to ensure people received consistent and appropriate care. During this inspection we found the provider had not made the required improvements.

On the first day of our inspection we arrived at the home at approximately 7.30am and observed care and support during the night shift and found there were not enough staff deployed. For example, at this time there was only one staff member on duty covering both the units on the first floor, Hockney and Lowry units. We observed the staff member left Hockney unit to serve drinks on Lowry unit. This meant the 13 bedded Hockney unit was left unsupervised. We saw there were five people up in the lounge on Hockney during this period. The lack of supervision of this unit increased the potential for incidents to occur and go unnoticed. A staff member told us it was challenging working across both units on their own and they "got to be in two places at once." We saw the staff member then went across to Hockney unit, leaving the Lowry unit unsupervised. Although the registered manager told us there should be four staff on night duty we found this was not always the case. For example the duty rotas showed that during the week commencing 24 July 2017 there were two nights when there were only three staff on duty. During the weeks commencing 31 July 2017 and 7 August 2017 there were respectively four and three nights with only three staff on duty.

We also had concerns about staffing levels and skill mix during the day. Senior care workers supported staff but were often busy administering medicines, and liaising with health professionals over people's care and support needs. The registered manager told us each unit should have a senior care worker but when we looked at the duty rotas we found this was not consistently the case. This meant the units were left with one

member of care staff while the seniors carried out duties, such as medicines administration, on other units.

We observed on Bronte Unit, between 11:15 and 11:30am, there was only one member of care staff working on the unit. The staff member told us they were unable to offer personal care when they were left alone on the unit as the communal areas needed to be supervised. They said this regularly happened when seniors were carrying out other duties.

On Hockney Unit we observed one of the staff went out to attend a funeral leaving two staff on the unit. Another member of staff was brought in to cover but there was an hour when there were only two care staff on duty. During this time we saw the domestic assistant had to break off from their duties to provide a staff presence in the lounge while the care workers attended to a person in their bedroom.

On the second day of our inspection we arrived at the home at approximately 8am. The night senior care worker told us there had only been three staff on duty overnight. During the day we observed care on Bronte Unit. We saw staff were able to respond to people's needs within a reasonable timescale. There were two staff members on the unit; however one of these was a senior care worker who we saw left the unit at times to attend to other matters. This meant there could be delays when people required two staff members for care.

The activities staff worked set days Monday to Friday, there were usually two on duty Tuesday, Thursday and Friday and one on Monday and Wednesday. On the first day of our inspection, due to sickness, there were no activities organisers on duty. As a result we saw a lack of social interaction and stimulation during the inspection with staff interactions being very task based.

On the first day of our inspection the registered manager showed us a dependency assessment tool which was used to help determine staffing numbers. They told us it should be reviewed every month but it has not been reviewed since March 2017. On the second day the new manager told us they were looking for an alternative dependency assessment tool as the one in use was not fit for purpose.

We concluded the provider remained in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In most cases we found risks to people's health, for example skin integrity, nutrition and falls were assessed through screening tools. These were then used to develop care plans instructing staff on how to control the risks. These were subject to regular review. We saw a number of different screening tools were used for nutrition and skin integrity which we concluded was an unnecessary duplication and could confuse the risk assessment process as they used different scoring scales. This concern was reinforced by our findings that risks relating to nutrition and skin integrity were not always well managed.

On the first day the inspection, we raised concerns about two incidents which had occurred in February and May 2017 and had not been adequately investigated. On the second day we raised these with the new manager but they were unable to determine whether action had been taken to investigate and/or learn from the events.

We reviewed accident and incident forms and did not note any concerning themes or trends.Since the start of July 2017 we saw incidents had not been subject to investigation and there were no outcomes recorded. Prior to this, investigations had taken place by the interim manager. Therefore there were a number of incidents which occurred in July and August 2017 for which we were unable to confirm the action taken to protect people from harm.

For example on the first day of the inspection we saw there had been three recent medicine errors in August 2017. One person had been given two doses of Paracetamol too close together, one at 7.45am and another dose at 9.30am by different staff. There should be a four hour gap between doses of Paracetamol. Two further discrepancies in medicines had been noted which indicated people had not always received their medicines as prescribed. On the first day of the inspection, the registered manager said these incidents were in the process of being investigated. Despite this, on the second day of the inspection we found there was no evidence of any investigations. We raised this with the new manager who said they were unaware and had not received a handover after coming back from annual leave.

We saw a safeguarding log was in place and a number of appropriate referrals had been made to the safeguarding unit within 2017. However on the first day of the inspection we saw there had been an incident which the manager said would be reported to safeguarding. On the second day we found a safeguarding referral had not been made. There was no investigation into the incident and the person's care plan for protection from abuse had not been updated following this with any additional safeguards.

We concluded there was a risk people who used the service would not receive care and treatment in a safe way. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the manager was in the process of undertaking accident analysis for August 2017 which would help ensure any themes or trends in accidents were identified.

One person who used the service told us, "I love my room here it is cleaned every day." One relative told us, "It is always nice and clean here, never seen it otherwise." Another said, "I have always found it to be clean and tidy"

We found the premises to be well maintained and suitable for its intended purpose. Bedrooms were nicely decorated and people had personal possessions on display. Essential safety checks took place on the building and equipment including to the gas, water and fire system. However we saw there were some gaps in the completion of these checks when the maintenance worker had been on holiday. Arrangements should have been in place to ensure these checks were consistently completed.

The home's training matrix indicated staff were required to attend fire safety training and take part in a fire drill every six months. However, the training statistics report showed only 37.5% of staff had attended fire safety training in the last six months and only 42.5% of staff had been involved in fire drill in the last six months. This should have been identified and rectified by the quality assurance and monitoring systems.

The two examples cited above demonstrated the providers quality checking processes were not operated effectively to ensure the safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service told us they felt safe. One person said, "I feel safe; I feel that the staff care for me. They are helpful." Another person said, "I feel safe, staff come and check me through the night, I think it's about every hour. When I'm having a bath staff know how to use the bath chair, this makes me feel safe." A third person said, "I do feel safe here, people look after me and take care of me, I get taken out, I am going to ASDA this afternoon."

The service supported some people to manage their spending money. This was typically money brought in by people's relative to be spent on items such as hairdressing and outings. Computerised records were

kept of all transactions and receipts were issued when money was received and when anything was purchased on people's behalf. The money was held securely and the administrator told us the previous manager had carried out random checks on the records and money.

People told us they usually got their medicines on time. One person said, "I have medication four times a day and it is usually on time." Another person said, "I take medication four times per day, it is usually on time, I know what I should be taking."

We looked at a sample of medicine administration records (MAR) which were well completed indicating people had consistently received their medicines as prescribed. The application of topical medicines such as creams was also consistently recorded. Stock balances of boxed medicines were kept to provide full accountability for all medicines. Where people were prescribed "as required" medicines we saw the administration of these was supported by protocols to ensure their safe and appropriate use. When people were receiving their medicines covertly, in a hidden or disguised form, there was evidence to show the best interest decision making processes had been followed.

Medicines were stored securely within locked trolleys. There were appropriate storage and recording arrangements in place for controlled drugs.

We looked at files of five staff the service was in the process of recruiting and saw the required checks were being completed before new staff started work. We spoke with one member of staff who had recently been recruited and they confirmed they were not allowed to start work until all the required checks had been done. This included references from their previous employer and a criminal record check with the Disclosure and Barring Service (DBS).

Requires Improvement

Is the service effective?

Our findings

Most people were happy with the food and the new chef. One person said, "We have lovely meals, we have a new chef and he's trying new stuff. He's doing his best." Another person said, "We have a new chef now and the food is very good. I am a very fussy eater, but there is plenty of choice, lunchtimes we have a hot dinner and pudding, tea time is usually soup, sandwiches and buns. This chef likes to make fresh food and not use frozen like before." A third person said, "The food is lovely now we have a new chef, he is very friendly and we have a choice, I get up early though so I have to wait for my breakfast." However, one person said, "I get a choice of food, not as happy with the meals now we have a new chef. Not always cooked as nice. Sometimes I don't eat it."

We observed the meal service at breakfast and lunch time on two units, Bronte and Hockney. At breakfast time people were provided with toast and cereals prior to a hot trolley arriving with options such as bacon, sausage and beans. On one unit we saw the chef came around to see people to see if they would like any extras, and a couple of people requested poached eggs. This prompted discussion amongst residents about how nice the poached eggs were. We heard one person say "He's very good, he does you what you want."

Similarly at lunchtime we saw people were offered a choice of meals and staff recorded people's preferences to ensure they received what they had requested. We saw snacks were available throughout the day including biscuits and milkshakes.

However, we found there was a lack of evidence to show appropriate action was being taken to support people who were at risk of poor nutrition or who had experienced unplanned weight loss.

We saw one person had lost nearly 10% in weight between June and September 2017 and they were now underweight with a Body Mass Index (BMI) of 18. A BMI of 18.5 to 24.9 is ideal for most adults. A BMI below 18.5 is in the underweight range (NHS Choices).

The person's care plan stated they were on nutritional supplements to increase their weight, but staff and medication administration records (MARs) showed these had been stopped in July 2017. Staff were unable to adequately explain why the supplements had been stopped and there was no record of any discussion with health professionals about this or the person's weight loss in general. The care plan contained a lack of adequate assessment of the person's needs and how to help them maintain a healthy weight. Although the person's food and fluid intake was being monitored there were gaps. For example, when it was recorded the person was asleep and there was no evidence staff had tried again later. We were therefore concerned that this person's nutritional needs were not met due to a lack of robust care planning and evidence of intervention.

In the records of another four people we identified similar concerns. In each case the person had a BMI which put them in the underweight range and we were unable to establish from their care records what action was being taken to address this. We were concerned this had not been identified by the provider until we brought it to their attention. We discussed our concerns during feedback and following the

inspection we referred our concerns to the local safeguarding unit.

We spoke with the chef who was relatively new in post. They told us there were not aware of people who needed their meals fortified. They said they had asked the manager for information about people with special dietary needs but this had not been provided.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw evidence the service worked with a range of professionals including GP's and district nurses over people's health. However the extent of this involvement was not always recorded. This caused confusion and meant staff could not adequately answer our questions about people's healthcare needs. For example, one staff member had to ring a staff member who was not on duty to find out information about healthcare intervention. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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.

There was a record of DOLS applications which showed when they had been applied for, whether or not they had been granted and where applicable the expiry date. The new manager told us they were reviewing all the DOLS applications.

We heard staff asking for consent and offering choices before offering care and support. This included assisting to help people mobilise around the home as well as giving choices over mealtime options and what people wanted to do. Care records showed that people had consented to some areas such as using the tele-medicines service. However there was a lack of evidence in some care plans that people had consented to their individual plans of care or that best interest processes had been followed

Most of the people we spoke with felt the staff knew what they were doing. One person said, I think the staff are trained well, they know what they are doing. The manager is new and is recruiting new staff and seems to have got some very nice staff." Another person said, "As far as I know all the staff are fully qualified, if I am not well I tell the staff or they notice and ask me if I am ok."

Staff told us they received the training they needed to carry out their roles. One new member of staff told us about their induction training. They said it had included the 'dementia bus' which they said was the best training they had ever done. The 'dementia bus' provides an experiential learning environment designed to help participants understand how people living with dementia perceive the world.

There was a training matrix which showed staff received training on variety of topics including health and safety, moving and handling, infection control, first aid, medication, food hygiene, safeguarding, dementia and the Mental Capacity Act. The matrix showed how often staff were required to update their training and this was monitored by means of a training statistics report. However, as reported in within the safe domain of this report shortfalls were not always identified and acted on in a timely way.

Requires Improvement

Is the service caring?

Our findings

People told us they were treated well by the staff. One person said, "The staff are very caring here and they know me well, they know my likes and dislikes, and if they don't then I tell them." Another person said, "The staffs are good, couldn't make them any better, I'm very happy with them. I have been happy since I moved in 4 year ago. I wouldn't want to live anywhere else." A third person said, "[They are] nice girls, they look after us here."

These views were echoed by the relatives we spoke with. One visitor told us, "The staff are always nice when we come, they are very friendly and chatty, always ask if we would like a cup of tea."

We saw staff helped people to keep in touch with their family and friends. While talking with one person we heard their mobile phone ringing in their bag. A care worker helped the person get the phone from her bag. The care worker told us the person's nearest relative lived abroad and so staff made sure their mobile phone was always charged so that they could receive their phone calls.

People told us staff respected their wishes and their privacy. One person said, "Staff listen to what I want, I can talk to them." Another person said, "Staff knock on my door and wait to come in, I like that." A third person said, "I go to bed about 10.30, night staff bring me a sandwich and a cup of tea. I get up around 8am."

However, one person we spoke with told us their dignity was sometimes compromised because staff were too busy. They said, "I have to wait to go to the toilet sometimes if they are too busy, it is awful sometimes because I have to wet myself, then they change me."

We found individual staff members were caring. However, we were concerned that the provider had failed to address the concerns about staffing levels raised at our last inspection. Therefore we could not be assured they were committed to providing a service based on the key principles of kindness, respect, compassion and empowerment.

We saw positive and caring interactions between staff and people that used the service. As people arrived in the dining room for breakfast they were greeted with a warm welcome from staff. For example one person was given a hug and a kiss by staff which made them smile. Staff chatted to people about their plans for the day, and about the food they were eating. This made for a pleasant and relaxed environment.

Care records we reviewed contained information on people's past lives to help staff deliver person centred care. Some of these however were rather brief.

We saw staff listened to people and people felt able to raise issues. For example we heard one lady approach the chef when he came around to see everyone in the morning to tell him that the fish fingers the night before were 'too small and hard'. The chef apologised, explained what had caused the problem and told the person they would order some different ones next time. This demonstrated that staff cared about

people's feedback and took action to act on their views.

We saw staff supported people to maintain their independence and this was confirmed by people living at the home. One person said, "I get up and go to bed when I want. Staff help me when I can't do things myself." Another person said, "Staff help me to get dressed; staff make me feel more independent."

People we spoke with were not always able to say whether or not they had been involved in their care planning. However, we saw in the care records that people who lived in the home and their relatives had taken part in care reviews.

People we spoke with told us they were kept informed and asked for their views about the service. One person said, "I think I have been to one residents meeting, they tell us what is going on here and ask our opinions, I would definitely recommend this place." Another person said, "I think we have had one residents meeting, we were told about the changes and I asked questions." They added, "I would recommend here, they do look after you." A third person said, "Now and again we have had residents meetings, we are told what's going on and we tell them what we think. I would recommend it."

The protected characteristics set out in the Equalities Act 2010 include religion or belief, age, disability, gender, and race. The key purpose of the Act is to protect people from discrimination based on any of these characteristics included in this legislation. From the feedback we received from people who used the service and our observations we were assured discrimination was not a feature of the service.

Within the care records we saw evidence people were supported to plan for their end of life care.

Requires Improvement

Is the service responsive?

Our findings

Most of the people and relatives we spoke with were satisfied with the care and support provided.

People's needs were assessed prior to admission to help ensure the service could meet their needs when they moved into the home. This information was then used to build a range of care plans in areas such as mobility, personal care and social activities. We saw most of these were appropriate and contained information for staff to follow.

However we identified a shortfall in care planning and delivery towards one person. Care records showed they had been risk assessed as being "at risk" of pressure sores in August 2017. Their skin had begun to breakdown on the 10 August, with district nurses involved who reported it had not improved by 4 September. At this stage, the home's risk assessment showed they were at very high risk in terms of skin integrity. There was no pressure area care plan or wound care plan in place detailing how the risk would be controlled. We saw there was confusion over the person's repositioning regime. On the 4th September, the district nurses had advised hourly position changes. This advice had not been translated into a care plan and there was no evidence this had been done. Following the installation of a new pressure relieving mattress on 5 September 2017, staff were unclear what the new turning regime now was and no position changes were recorded. We saw this person was now spending a large amount of time in bed. We were concerned that someone who was of high risk of pressure sores and whose skin had broken down did not have a pressure area care plan in place. This was discussed with the manager at feedback who assured us it would be dealt with as a matter of urgency.

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

People's care and support plans were subject to regular monthly review. We also saw annual care plan reviews took place which involved the person, their relatives and relevant professionals such as social workers.

We asked people who used the service about activities. One person said, "There are some activities here, but it has been a bit quiet because of the staff shortage. I like the Arts and Crafts, we are making things to trim up for Halloween, they do bingo but I'm not keen on that, we have occasional themed days 2 or 3 a year, the new manager has new things lined up, such as trips and meals out, I'm going to butterfly world in Leeds this week."

Another person said, "I go out when I want to, or I play bingo, but not musical bingo I don't like that, I like quizzes best." A third person said, "I like to go out, they take me to the charity shop and supermarket, I like to knit and read, I'm not keen on the other things like Bingo that they do."

A relative told us, "There always seems to be something going off, and she always seems content and happy when we visit."

The home employed three activities staff. However they also had other roles such as caring and housekeeping and were routinely taken off activities to provide cover in these areas. On the first day of the inspection there were no activities organisers on duty and on the second day there was only one working. This meant people were not consistently provided with opportunities and support to take part in social activities. During the second day of our inspection we saw the activities organiser who was on duty went around all the units to ask people if they wanted to play Bingo or do some arts and crafts.

We recommend the provider reviews the arrangements for supporting people to take part in person-centred activities within the service or in the community and encouraging people to maintain their hobbies and interests

People told us they knew who to talk to if they were unhappy about anything. One person said, "If I was not happy, I would speak to the manager." Another person said, "I don't need to complain, I am looked after." A third person said, "If I had a problem I would tell [staff name] my senior care worker, she works three days or the manager [name of new manager].

We saw the provider kept a complaints log. The last complaint recorded in the log was May 2016. However, we were aware there had been a complaint about the service earlier in 2017 and this was not in the complaints log. The registered manager, who was present during day one of our inspection, told us this had been dealt with at the providers head office and they provided us with a copy of the response.

We also found concerns raised by relatives were not always recognised and recorded as formal complaints. For example in one person's records we saw their relative had raised concerns about dehydration and in another case a relative had raised concerns about how the service supported the person to manage their cigarettes. Although action had been taken to address these concerns they had not been logged as complaints.

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

The new manager had started to have weekly drop in sessions where people and relatives could discuss any issues or concerns and make suggestions for improvements to the service.

Inadequate

Is the service well-led?

Our findings

The manager who was registered for the service was no longer working there. They had been moved to another service operated by the provider in January 2017.

Between January and July 2017 two managers had been appointed and subsequently left the service. In July 2017 a new manager was appointed and they told us they would be applying for registration with the Care Quality Commission. The post of deputy manager was vacant and recruitment was in progress.

Although a range of audits and checks were undertaken covering areas such as health and safety, the environment, medicines, dignity and respect and the dining experience we found quality assurance systems and processes had not been consistently operated at a high level in the months prior to the inspection. For example, we found the quality and presence of incident investigations varied over the last few months. We concluded the number of changes in management may have contributed to this.

The new manager was being supported by a consultant who was providing support setting up and implementing new systems of governance. For example an audit schedule was being developed to structure the daily, weekly and monthly checks which were to be undertaken by the manager. The provider had an action/improvement plan in place.

Staff told us changes had been made to the organisation and deployment of staff which meant that staff no longer worked on set units within the home. This was confirmed by the new manager.

We found the changes were not supported by effective communication systems which potentially compromised people's care. For example, some of the staff we spoke with demonstrated a lack of accountability for working on the units. In one instance when we asked a staff member whether anybody was on a turning regime, they responded "I don't think so, but I don't normally work on this unit". We saw this staff member was working alone at times and should have had access to this information.

On one unit we spoke with a senior care worker about healthcare interventions undertaken for one person. They were unclear about what decisions had been made and why. They said, "[staff] member was running the floor and left so it's hard to explain some of the decisions made". They phoned another senior care worker who was not on duty to find out information relating to the person's needs. Similarly on another unit when we asked a senior care worker about changes to a person's care they were unable to demonstrate when and why the changes had been made and who had been involved in the decision making process.

Some of the people we spoke with and relatives also expressed concerns about the staff changes. In reference to the new manager one person said, "I don't think she is a 'hands on' manager, she stays in the office. She wants to mix the staff between floors but I like our staff, the other staff don't know us and it is upsetting." A relative said, "I do think mum is looked after very well, and most of the staff are confident in what they are doing, but they are having a lot of changes of staff and I think it unsettles mum."

During this inspection we found the provider had not taken appropriate action to address the concerns about staffing raised at our previous inspection. In addition, to the continued breach of regulation 18 (Staffing) we identified three new breaches of regulation. These related to safe care and treatment, meeting people's nutritional needs and governance. This meant the service fell below the required standards for a good service.

We acknowledge the provider had made a commitment to improving the service and has arranged for the consultants to visit the home and support the manager on a weekly basis. However, at the time of our inspection we were not assured the systems for assessing and monitoring the quality and safety of the services being provided were as effective as they should be.

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

People's views and feedback were sought. The new manager had held a relatives meeting to introduce themselves to people. Annual quality surveys for 2017 were due to be sent out in October 2017 to obtain people's views on the service. Care reviews took place with people and relatives and the manager had an open door policy. All the people we spoke with told us they would recommend the service.

The rating was displayed in the home as required by law.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who used the service were at risk of receiving unsafe care and treatment. Regulation 12(1)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's nutritional and hydration needs were not always met. Regulation 14(1)

The enforcement action we took:

Impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and process were not operated effectively to ensure compliance with the regulations and assess, monitor and improve the quality and safety of services. Accurate records were not maintained. Regulation 17(1) (2)(a)(c)

The enforcement action we took:

Impose a condition.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff deployed to make sure people received safe and appropriate care. Regulation 18(1)

The enforcement action we took:

Impose a condition