Handsale Limited

Handsale Limited - Bierley Court

Inspection report

49A Bierley Lane
Bradford
West Yorkshire
BD4 6AD
Tel: 01274680300
Website: www.handsale.co.uk/bierleycourt

Date of inspection visit: 14 October 2014
Date of publication: 06/03/2015

Ratings

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

Overall summary

We inspected the service on 14th October 2014. This was an unannounced inspection.

Handsale Limited - Bierley Court provides accommodation and personal care to a maximum of 40 people. On the day of our visit there were 38 people living at the home. Most of these people were older people and people living with dementia

The accommodation is arranged over two floors linked by a passenger lift. The home is divided into three units which includes a general residential unit, an early stage dementia unit and an advanced dementia unit. All bedrooms are single rooms with en-suite toilet facilities. There are communal lounges and dining areas for people to use.

Summary of findings

The home has a registered manager in post. 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 and associated Regulations about how the service is run.

Whilst there were appropriate procedures in place to ensure the safe management of medicines; the processes in place where people received covert medicines were not robust. We recommend that the provider considers The National Institute for Health and Care Excellence (NICE) guidance 'Managing Medicines in Care Homes' to ensure all covert administration of medicines takes place within the context of existing legal and best practice frameworks.

Overall staffing levels were adequate to ensure people's individual needs were met. However, we found staffing arrangements required improvement. For example, additional senior staff needed to be recruited to ensure there were consistent levels of staff on duty at all times and the dependency assessment used by the service needed updating.

People and staff spoke positively about the manager and said they were approachable. People told us they knew how to make a complaint and were asked for their feedback about how the service was run. However, some aspects of the management of this service had not been consistently delivered. We found there were not robust arrangements in place to ensure joined-up care was delivered when working in partnership with health care professionals. Improvements were also required with regard to how other incidents were investigated and recorded. The service had quality assurance systems in place to monitor whether the service was providing high quality care. However, the provider's checks and audits of the service were not being recorded.

Staff had a good awareness of what to do in the event of an emergency. However, clearer guidance was required about what staff should do in the event of a medical emergency.

People who lived at the home and their relatives consistently told us the standard of care provided was good. They told us the food was, "Tasty", they felt safe and comfortable around staff and felt involved in making decisions about the care and support they received.

From our observations and discussions with people we saw that staff treated people with dignity, respect, warmth and kindness. Staff knew people well and had appropriate training and support to enable them to provide safe and effective care. Staff had a good awareness of how to keep people safe and report abuse.

Care plans were easy to follow and provided staff with sufficient information. We saw examples where the care provided was in line with the requirements in people's care plans.

Staff were aware of their duties under the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA) and how to ensure the rights of people with limited mental capacity when making decisions was respected. Systems were in place to monitor and manage any situations where people's freedom may have been restricted.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. There were appropriate procedures in place to ensure the safe management of medicines. However, the processes in place where people received covert medicines were not robust.

Staffing levels as planned on the rota were sufficient to meet people's needs. However, staffing levels required improvements to ensure there were sufficient numbers of staff recruited to ensure consistent levels of staff on duty. The tool used to calculate staffing levels required amendments to ensure it was effective. We found that recruitment practices were safe and relevant checks had been completed before staff had worked unsupervised at the home.

People told us they felt safe living at the home. Staff had a good awareness of how to recognise and respond to abuse.

Staff had a good awareness of what to do in the event of an emergency. However, clearer guidance was required about what staff should do in the event of a medical emergency and who the out of hours emergency contacts were.

Is the service effective?

Good

The service was effective. Staff received appropriate support and training to provide them with the skills to deliver effective care.

We saw people had access to a range of health professionals to help maintain their health and wellbeing.

From our observations, discussions with people and our review of records we saw evidence which demonstrated consent was sought and was appropriately used to deliver care.

We found the service to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Staff we spoke with had a good understanding of the Mental Capacity Act (MCA) and how to ensure the rights of people with limited mental capacity when making decisions was respected.

We saw evidence people were effectively supported to have enough to eat and drink.

Is the service caring?

Good

The service was caring. People consistently told us that the standard of care provided was good. From our observations and discussions with people we saw that staff treated people with dignity, respect, warmth and kindness. Staff knew people well and how each individual liked to be supported.

Summary of findings

Care plans were easy to follow and provided staff with information about people's individual preferences, how they wanted their care to be provided and how they could encourage people to maintain their independence. We saw examples where the care provided was in line with the requirements in people's care plans.

People and their relatives told us they felt involved in making decisions relating to how their care was delivered.

Is the service responsive?

Good

The service was responsive. Staff supported and encouraged people to take part in social activities. This included activities which were appropriate to the needs of people living with dementia.

An effective complaints system was in place and people were aware of the process if they wanted to raise a complaint. People were asked for their views about the service and this feedback was used to improve the way the service was run.

People and their representatives were involved in reviews of care. This helped staff to ensure they were delivering care which was relevant, up-to-date and inclusive of those who could make a meaningful contribution to the health and welfare of people.

Is the service well-led?

Requires Improvement

The service was not always well-led. People and staff spoke positively about the manager and said they were approachable. However, prior to our visit the manager had been providing support to another service. This meant some aspects of the management of this service had not been consistently delivered.

We also found there were not robust arrangements in place to ensure joined-up care was delivered when working in partnership with health care professionals.

Incidents such as falls and behaviour that challenged the service were recorded, monitored and actions were taken to help reduce risks for people. However, improvements were required with regard to how other incidents were investigated and recorded.

The service had quality assurance systems in place to monitor whether the service was providing high quality care, most of the audits were completed and recorded by the manager or senior staff. The provider also visited the home regularly. Improvements were required to demonstrate the effectiveness of these checks as there were no records kept of the provider's audits.

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 checked 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 14th October 2014 and was unannounced.

The inspection team included three 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. The expert-by-experience used in this inspection had experience of dementia care.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed this information along with other information we held about the provider. We contacted the local authority commissioning team and local healthwatch to ask them for their views on the service and if they had any concerns.

During the inspection we used a number of different methods to help us understand the experiences of people who used the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with eight people who lived at the home and four visitors. We spent time observing care and support being delivered. We looked at five people's care records, 10 Medicines Administration Records (MAR) and other records which related to the management of the service such as training records, policies and procedures. We spoke with the manager, deputy manager, five members of care staff, the maintenance man, laundry assistant and domestic staff. As part of the inspection we also spoke with six health care professionals who regularly visited the service. After the inspection we also spoke with a fire safety officer who had recently visited the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe and comfortable around the care staff. One person told us, “I like living here, the staff are kind and I feel safe.” A visitor told us, “My [relative] needs a safe place to be where they can come to no harm and be of no harm to others. I am completely content that the home is providing the right environment for their care.” The care staff we spoke with told us they felt people were safe and they would be happy if one of their relatives came to live at the home.

We found medicines were stored safely and only administered by staff who had been appropriately trained. We looked at ten people’s medicine administration records. We found these were up to date with no gaps in recording. We found most people had protocols in place to guide staff about when and how to administer “as required" medication. We saw evidence of staff adhering to these protocols, such as asking people if they were in pain before determining whether to administer their “as required” pain relief. However, two people’s “as required” protocols were missing from their medication records. We raised this with the registered manager who said they would ensure “as required” protocols were in place for all people who required them.

During our observations we saw staff gave people their medicines in a safe way which met their individual needs. However, we observed one staff member give one person a chewable supplement without checking they had fully swallowed the tablet before leaving them. To ensure people take their medicines safely staff should remain with people until they have fully taken their medicines. We raised this observation with the provider following our inspection. They agreed to complete a full check of this staff member’s competency regarding medicines administration.

During our inspection senior care staff informed us one person received their medicines covertly. This meant the person was given their medicines without them knowing. This person had their liquid medicine dissolved in a drink. We checked their care records and saw no formal mental capacity assessment had been done. We discussed this with the registered manager. They were unable to provide us with appropriate documentation to evidence this decision was made in this person’s best interests and in line with the provisions under the Mental Capacity Act 2005. There was also no evidence to show a discussion had been held with a pharmacist to determine the safest method of disguising the medication. This put this person at risk of not receiving their medicines in a safe and appropriate way. We asked the provider to make the required improvements to ensure the procedures for the covert administration of medicines are robust, in line with best practice guidance and being correctly followed by staff.

The service had introduced a dependency tool to assess staffing levels. The manager agreed the tool required further development to ensure it’s effectiveness and accuracy. We spoke with three care staff specifically about staffing levels. Two out of the three staff said there were enough staff. One said there were occasions when there were not enough senior staff on duty. During the day, a senior carer was meant to supervise each of the three units. However, there had been occasions where only two senior carers were available to cover the three units. This put a strain on senior tasks such as completing care records, administering medication and communicating with health professionals. We spoke with four members of the district nursing team who visited the home on a weekly basis. They told us it was sometimes difficult to get hold of senior staff to discuss issues. We looked at the rotas and found that although overall staffing levels were consistent, there were some occasions in the weeks prior to our inspection when only two seniors were on duty. The manager recognised this had been a problem and showed us they had vacancies advertised for additional senior carers. During the inspection there were three seniors on duty. We observed care and found there was adequate staff to meet people’s needs. People and visitors we spoke with did not raise any concerns about staffing levels . Although staffing levels as planned on the rota were sufficient to meet people’s needs these were not always consistent in practice.

We found relevant checks had been completed before staff had worked unsupervised at the home. We spoke with a new member of staff who confirmed a Disclosure and Barring Service check and two references had been completed before they started work in the home. These procedures helped protect people from the risk of being cared for by unsuitable staff.

Disciplinary procedures were in place to keep people safe. However, we found the recording of incidents relating to disciplinary could be improved. For example, one staff

Requires Improvement

Is the service safe?

member had recently been subject to disciplinary action. We found that although proper processes had been followed to keep people safe. The full details of the incident had not been fully recorded so it was difficult to establish the level of risk to people. We also found the incident had not been reported to the Care Quality Commission (CQC) or the Bradford Adult Protection Unit, despite it being a safeguarding issue. We spoke with the registered manager about this, they said it was a mistake and they would ensure it did not happen again. They said they were clear about their responsibility to notify the CQC about incidents that affect the health, safety and welfare of people whilst they used their service. From the information we hold about the service we know the service has notified the CQC about other safeguarding incidents.

Staff we spoke with told us they had received training in safeguarding adults and were clear about how to recognise and report any suspicions of abuse. They were also aware of the processes for taking serious concerns to outside agencies if they felt they were not being dealt with effectively. This showed us staff were aware of the systems in place to protect people and raise concerns about safeguarding.

Emergency procedures were in place. This included a clear fire procedure which provided guidance for staff, residents and visitors which was on display in communal areas. Staff had been trained in fire and emergency procedures and spoke confidently about the action they would take in the event of a medical or fire emergency. There was no procedure on display detailing what to do if medical issues arose in the home and who the out of hours emergency contacts were. This risked that staff would not consistently follow the correct procedure in the event of a medical emergency if the manager was not present. This was raised with the manager who said they would address this issue as an immediate priority.

We reviewed five care files. We saw there were risk assessments in place which identified potential risks for people and how these could be reduced or managed. This included; pressure care, moving and handling, nutrition and falls.

We found the premises to be safely managed. There were appropriate facilities for people and the premises was well maintained and secure. There was a secure garden area which people told us they enjoyed accessing. Periodic maintenance and checks of equipment were in place to help keep people safe, such as fire alarms, the lift, hoists and gas and electrical appliances. This demonstrated the provider was mindful of the need to provide a secure and safe environment in which to care for vulnerable people.

We saw that West Yorkshire Fire Service had issued the home with a fire safety enforcement notice on 6th August 2014. After our inspection we spoke with the fire officer who issued the notice and they confirmed they had returned to the home in September 2014 and found that appropriate improvements had been made to comply with the requirements of the notice.

We recommend that the provider considers The National Institute for Health and Care Excellence (NICE) guidance 'Managing Medicines in Care Homes' to ensure all covert administration of medicines takes place within the context of existing legal and best practice frameworks.

Good

Is the service effective?

Our findings

People told us staff appeared to be well trained and competent. One relative told us, “I visit twice a day, but I have the peace of mind that staff will care for my husband if I don’t come in – they are marvellous”. Another relative told us, “Staff are marvellous”.

The care staff we spoke with told us they felt the training they received provided them with the necessary skills to undertake their role effectively. Staff told us they felt supported in their role and had regular supervision and appraisals where they felt able to raise any concerns or development needs they had. We saw staff supervision and appraisal records which confirmed this. We saw staff received a range of training which included mandatory subjects such as fire safety, fire drills, food hygiene, moving and handling, dementia and safeguarding. Specialist training had also been provided by the local district nursing team including pressure area care and diabetes. An overview of all the training staff had undertaken was available so the manager could monitor if training had lapsed. We reviewed this and saw most staff were up to date with their mandatory training. Training records also showed induction training took place which included going through all the local policies and procedures with new staff and provide practical training such as manual handing.

We saw evidence staff had accessed other services in cases of emergency or when people's needs had changed. This included doctors, consultants and health care specialists. For example, one person had been identified as having swallowing difficulties and a referral had been made to the speech and language therapist. Information in the speech and language therapist's report had been transferred into the person's care plan. Another person had been discharged from hospital with a fractured femur. Following their discharge the care plan demonstrated the hospital’s continuing care advice had been translated into a new plan of care. The plan also noted the inclusion of a visiting physiotherapist to encourage mobilisation and enhance rehabilitation. The daily activity notes showed the care staff participated in the rehabilitation programme. This showed

where people had been referred for care to another provider the resulting advice was followed. However, when we spoke with members of the local district nursing team and the community matron we found improvements were required to ensure a joined-up approach in how care was co-ordinated and delivered. We have asked the provider to make improvements to address this in the “Well Led” section of this report.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The manager was aware of the recent DoLS Supreme Court judgement and demonstrated they had followed the requirements in the DoLS. They had made two recent applications for people they deemed to be at risk. The manager was still waiting for authorisation for both applications so we were unable to check whether the service was complying with any conditions which had been applied. We found 68% of staff had received training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards. We examined the provider information return (PIR) prior to the inspection which identified that not all training was up to date in this area and this was being addressed as a priority.

Despite the training shortfall, the staff we spoke with demonstrated an understanding about the Mental Capacity Act and DoLS and how to protect the rights for people with limited mental capacity when helping them to make decisions. They were able to give examples of instances when best interest decisions had been made with the involvement of relevant professionals. We also spoke with staff about the role of Independent Mental Capacity Advocates (IMCA) as defined in the Mental Capacity Act 2005 (MCA). The answers we received demonstrated a good understanding of the importance of the role and when to request IMCA involvement.

Care plans evidenced information regarding people's capacity to make decisions. This helped protect people against the risk of excessive and unlawful control or restraint. We also saw documents in care plans where people had given consent to specific areas such as having their photographs taken and sharing medical information with other health care professionals. Some people had ‘Do not attempt cardio-pulmonary resuscitation’ (DNACPR) orders in place. Where this was the case we saw these had been completed appropriately in consultation with a relevant healthcare professional and discussed with the person or their family. We spoke with staff who knew of the DNACPR decisions and were aware these documents must

Good

Is the service effective?

accompany people if they were to be admitted to hospital. From our observations, discussions with people and review of records we saw evidence which demonstrated that consent was sought and used appropriately to deliver care.

Following our inspection we spoke with the community matron who told us sometimes when they visited people were not left with cold drinks. They told us this was a particular problem for people who spent time in their rooms because although they were provided with jugs of juice, when these were taken away to be replenished it would sometimes be some time before a fresh jug was provided. During our visit we saw evidence people were offered drinks and snacks at regular intervals during the day and we observed that people who spent time in their rooms had jugs of juice provided. However, raised this feedback with the registered manager who assured us they would monitor this to ensure people always have access to sufficient fluids.

We saw evidence people were effectively supported to have enough to eat. We observed breakfast and lunch during our visit and saw there was a suitable choice of fresh and appetising foods available for people to choose from.

The atmosphere during mealtimes was relaxed and choices were clearly explained to people. Nutritional risk assessments had been completed which identified if the person was at risk of fluid imbalance or malnutrition and reflected the level of support they required for eating and drinking. Where people were identified as being at risk, food and fluid charts were in place to help staff monitor how much people were eating and drinking.

On the day of our visit the cook was absent so kitchen duties were covered by the maintenance man. We spoke with them about special diets, such as how they catered for diabetics and people identified as having swallowing difficulties. Their responses showed they had a good understanding of people's dietary needs and how to meet them. Staff told us menus changed with the seasons and people contributed to the discussions to compile the menus. We were told that each day there was choice for the main meal with additional options of omelettes, jacket potatoes and salads being available as alternatives. Our discussions with people confirmed this. People told us the food was, "Delicious", "Very good" and, "Tasty".

Good

Is the service caring?

Our findings

People consistently told us the standard of care provided was good. They said staff were very caring and treated them with dignity and respect. One person told us, "The staff are lovely, they ask what I need help with." Another person told us, "They (the staff) treat us with respect." A relative said "They are absolutely fabulous, they have taken the worry away for me". People also told us they felt settled and comfortable living at the home. One person said, "It feels like my home now."

We used the Short Observational Framework for Inspection (SOFI) to observe interactions and activities in the home. We found staff treated people with dignity, respect, warmth and kindness. Staff appeared caring and eager to meet residents' needs. We saw people were smiling, looked happy and relaxed and laughed and joked with staff. This helped contribute to a relaxed and homely atmosphere. We observed staff included people in conversations about what they wanted to do and explained any activity prior to it taking place. People looked clean, appropriately dressed, had their hair brushed and were clean shaven. It was clear staff had taken time to provide support and encouragement to people with their personal care.

Care plans were easy to follow and provided staff with information about people's individual preferences and how they wanted their care to be provided. We saw they contained information about what the person could do for themselves and identified areas where support was required. This helped provide staff with information to help encourage people to retain their independence. We saw examples where the care provided was in line with the specific requirements in people's care plans.

Staff were able to tell us about people's care needs and the support they provided to people. They demonstrated an in-depth knowledge and understanding of people's different personalities, preferences, routines, likes and dislikes. This was supported by our observations which showed staff knew people well and how best to support them. During our visit we saw friendly and appropriate banter between people and staff. This showed us staff had built meaningful and appropriate relationships with people.

Visitors told us they felt welcome whenever they came to the home. Friends and relatives told us they could visit at any time but were asked to avoid mealtimes to avoid distractions for people and staff. We saw staff spoke with visitors and helped to make them feel welcome. For example, one relative was invited to sit at the table and get involved in a game of Bingo that was being played.

People and their relatives told us they felt involved in making decisions relating to how their care was delivered. One relative told us, "We are always involved in decisions about my [relative's] care. My [relative] is not able to make some decisions and I have the authority to act on their behalf." Another relative told us, "We were involved with [my relative's] care plan when they came in." We saw people and their relatives were invited to care reviews which were usually annual, or sooner if there was a specified need. The personalised information within people's care plans also showed us they had been developed in conjunction with people and their relatives.

We saw bedrooms were personalised with pictures and ornaments and where bedrooms had been redecorated people had made decisions about the decoration and furnishings. Some people chose to have keys to their bedrooms. One person told us, "I like to lock my room when I am not in there, it's like my own front door."

Good

Is the service responsive?

Our findings

People were supported and encouraged to take part in social activities. The service employed two activities coordinators who worked five days a week. During our visit they engaged people in a range of activities such as bingo, skittles and reminiscence. Individual activity records were in place which confirmed people received a mixture of one to one support as well as group based activities. The home had a minibus which was shared with another home and we saw evidence this was used to arrange periodic trips out such as visits to the seaside, shopping trips and a coffee morning at a local church hall. We saw signs throughout the home advertising a bonfire party and a violinist concert during the month of our inspection. The activities coordinator explained they found activities based on life history and reminiscence were more appropriate on the dementia unit. The manager described a Coronation Street reminiscence event was being planned with staff and people at the home taking part. This demonstrated the provider's understanding of the importance of reminiscence, life story work and cognitive stimulation in bringing benefit to people with dementia.

Most people told us they felt stimulated and involved in social activities. One person told us, "I don't feel neglected at all even though I spend a lot of time in my room". Another person said, "I usually play games but don't want to go on trips out anywhere.".However, two people who spent most of their time in their bedrooms told us they were sometimes bored. One person commented, "I am fed-up, there is nothing to do and I am bored." We raised this with the manager who said staff did try to engage these people in activities and provide them with one to one engagement with staff. However, they recognised this was not formalised as part of the activities programme and was usually on an ad-hoc basis. They said they would ensure this was addressed.

We found an effective complaints system was in place. No complaints had been received in the year prior to our inspection. The manager told us in the past the learning points from all complaints were referred to in staff supervisions and staff meetings. We noted that since the last complaint the provider had put in place a formal record sheet which required outcomes and learning points to be recorded. This demonstrated the provider was striving to drive up quality by engaging in reflective practice. People we spoke with said they would speak to the manager if they had any concerns or complaints and they felt confident they would take those concerns seriously. We spoke with a member of staff who was able to tell us how they would support a person who used the service to make a complaint. The Provider Information Return (PIR) also showed the service was to introduce monthly meetings with senior staff to discuss any concerns or on going complaints so these could be monitored more closely and any learning points cascaded to all staff.

The manager told us an assessment was completed before people moved into the home to make sure staff could meet the person's needs. We saw evidence of this in the care records we reviewed. This included; a falls risk assessment, nutritional needs, skin integrity, and a comprehensive life history. We saw evidence that people and their relatives were then involved in developing their care plan.

Care plans had been, as a minimum, reviewed monthly to ensure there was up-to-date information on the person's needs and how these were to be met. Additional reviews were undertaken in response to such matters as visits to hospital consultants or other healthcare professionals. We saw that a yearly review was undertaken between people receiving care, their relatives, care workers and the manager. This helped staff to deliver care which was relevant, up-to-date and inclusive of those who could make a meaningful contribution to the health and welfare of people.

Staff handovers took place at the beginning of each shift. Staff explained that during handovers each person was spoken about and any changes in their care needs were discussed. This ensured staff could provide responsive care. We looked at the handover book and saw a written record existed of key issues which had been passed on to incoming staff. The written report was expanded upon during the verbal handover.

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. People we spoke with provided positive feedback about the registered manager. They told us they felt able to raise issues with them and had confidence they would take action to address any concerns they had. We saw the registered manager made themselves accessible to people if they wished to discuss issues or concerns. There was a sign in the entrance to the home which invited people to a monthly manager's surgery or to make an appointment to discuss any issues they may have.

In the two months prior to our inspection, the registered manager had provided support to another service owned by the provider. This meant they had spent most of their time away from the home. In their absence the deputy manager had taken on the day to day management responsibilities. From our conversations with people, health professionals and staff and our review of records it was clear that whilst the registered manager had been away some aspects of the management of the service had not been consistently delivered. For example, there had not been a senior team meeting or care staff meeting since April 2014. Also when we asked for updates about certain people who used the service or for specific documentation the manager and deputy manager was unable to provide this. This included information about the covert administration of medication to one person and the status of a DoLS application for another person.

We spoke with the registered manager about this and reminded them of their legal responsibilities outlined in the Health and Social Care Act 2008 and associated Regulations. They explained they had now returned full time to the home and would focus on catching up with all management duties as an immediate priority.

We spoke with four members of the district nursing team and two community matrons who visited the home on a regular basis. They all told us of a lack of consistency with regard to their advice or requests being followed. They said their advice was not always effectively communicated and whether appropriate action was taken to adhere to their recommendations depended on which staff were on duty. We spoke with the manager and senior staff about this. They showed us examples where they had followed the advice of the district nursing team but explained that sometimes their instructions were not always clear. The manager recognised that communication needed to improve. Both they and the visiting health care professionals agreed to arrange a meeting to develop an agreed communications strategy which focussed on the need to deliver co-ordinated care.

Prior to our inspection the Care Quality Commission were contacted by West Yorkshire Police (WYP) about an incident that had occurred at the home in July 2014. WYP raised concerns about staff culture and attitudes. They were concerned that staff had not brought the incident to the attention of the manager in a timely manner and had not followed the correct emergency procedures. The manager explained they had taken action to address this. For example, during supervisions all staff had been spoken with about the relevant protocols for emergency procedures and reporting incidents. From our conversations with staff we found they were confident about the emergency protocols in place in the home and when to report areas of concern to management.

During our visit, we found that incidents such as falls and violence and aggression were recorded, monitored and actions were taken to help reduce risks for people. However, we saw that improvements were required with regard to how other incidents were investigated and recorded. For example, we saw an incident had occurred in March 2014 where a number of fire alarm glass panels had been smashed. Whilst the registered manager was able to describe the actions they had taken, they were unable to provide us with an investigation report which evidenced their actions. The registered manager told us they would ensure more robust investigation records were kept in the future.

The service had quality assurance systems in place to monitor whether the service provided high quality care. The registered manager and senior staff completed periodic checks and audits which included; care records, medication, infection control, health and safety checks and audits of the kitchen and laundry facilities. The registered manager had their own audit planner which enabled them to keep track of which checks had been completed and what actions were required. They also explained that as a result of the last CQC inspection they had introduced a manager's audit as previously their daily tours of the building, conversations with people and checks were not

Requires Improvement

Is the service well-led?

recorded. We saw improvements had been made because a new record had been developed to capture this information and evidence the checks the registered manager completed and any required actions.

The registered manager explained the operations manager visited the service monthly to conduct a provider audit. This included checks of care records, accidents and incidents, monthly weights, staff training and audits. The registered manager told us at the end of the visit they would be informed of any actions or improvements that were required. However, they were unable to provide us with any evidence of the visits because they did not receive a copy of the providers audit report or an action plan.

Following our inspection we spoke with the provider about this and they agreed to keep an auditable trail of their contribution to improving the quality of the service provided.

People were asked for their views about the service and this feedback was used to improve the way the service was run. There were 'residents and relatives' meetings held every three months and a series of satisfaction questionnaires which people completed throughout the year about topics such as food and activities. The results from the latest survey conducted in November 2013 were displayed in the home and showed people were happy with the standard of care they received. A newsletter was also sent out to people and relatives every three months to keep people up to date with events, improvements and any changes.