James and Reuben Limited

Holly Bank Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We inspected Holly Bank Care Home on 1 June 2016 and the visit was unannounced. Our last inspection took place on 8 August 2014. At that time, we found the provider was meeting the regulations we looked at.

Holly Bank Care Home is situated on the outskirts of Halifax town near Manor Heath park. It is registered with the Care Quality Commission to provide personal care for a maximum of 25 people. Nursing care is not provided. The accommodation is arranged over four floors and there is a passenger lift available. Bedrooms are on all four floors, there are two doubles and 21 single rooms. Five bedrooms have en-suites toilets and 13 have en-suites showers and toilets. Car parking is available at the front of the building.

On the day of the inspection there were 22 people using the service and one person was in hospital.

There is a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

We found the home was well decorated, comfortably furnished, clean and tidy. There was a relaxed friendly atmosphere and people looked well cared for. However, we identified a number of areas where improvements were required.

We found staff were being recruited safely, however, the duty rotas did not always show which members of staff were on duty or in what capacity they were working. The registered manager was not using any formalised tool to calculate how many staff were needed, based on the dependencies of people using the service. This meant we could not assure ourselves there were always enough staff on duty to met people's needs.

Staff were receiving training which was relevant to their role and they told us they received regular supervision. There was no appraisal system in place to ensure staff performance and developmental needs were being identified and addressed.

People who used the service and their relatives told us staff were helpful, polite, professional and caring. We

saw people were treated with respect and compassion.

Although people told us they felt safe at Holly Bank Care Home we found some incidents had not been reported to the safeguarding team and the Commission. This meant the procedures to keep people safe were not being followed.

There was no dedicated cook, the registered manager told us some of the care staff took it in turns with the catering. They also told us they had no intention of employing a chef or cook in the future. Although people told us the meals were good, we saw the menus did not incorporate people's preferences, which had been discussed at a residents' meeting.

Care plans were not up to date, did not detail exactly what care and support people needed and were not personalised. Risk assessments were in place however, these were not always accurate and action had not always been taken to mitigate identified risks.

People's healthcare needs were being met, however, we found medicines were not being stored or managed safely. Staff were not always signing medicine records to confirm they had administered medicines and there was no guidance for staff regarding the administration of 'as required' medicines.

We found the service was not meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS). We found one DoLS had expired and there was no evidence the conditions which had been in place for someone who had left the service had been met.

Some activities were organised by the care staff to keep people occupied.

People told us their visitors were made to feel welcome and if they had any concerns they would speak to the one of the staff.

We found checks being made on the overall operation and quality of the service were poor and were not identifying areas which required improvement. The registered manager had had been given advice from the local authority contracts officer about this, but had not followed their advice.

The registered manager had not always informed us about events in the home, as they were required to do. We found they were not following the Commission's current guidance or legislation which meant they were not up to date with current requirements.

Overall, we found significant shortfalls in the care and service provided to people. We identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found.

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

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

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

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any

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

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

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 staff were recruited safely, we could not be assured there were always enough staff on duty to meet people's needs.

Staff were not recognising or reporting safeguarding issues and did not understand how to identify and manage risks to people's health and safety.

Medicines were not stored or managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

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

We found the service was not meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS).

People had a choice of meals but the menus did not reflect people's preferences.

Records showed people had access to healthcare professionals, such as GPs, opticians, district nurses and chiropodists.

Is the service caring?

Good

The service was caring.

People using the services told us they liked the staff and found them helpful, friendly and kind. We saw staff treating people in a patient, dignified and compassionate way.

People looked well cared for and their privacy and dignity was respected and maintained.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always accurate, up to date or in place. Care delivery was dependent on the staff's knowledge of people's needs.

There were some activities on offer to keep people occupied.

People knew how to make a complaint and the complaints procedure was
displayed in the home.

Is the service well-led?

Inadequate

The service was not well-led.

People were not protected because the provider did not have effective systems in place to monitor, assess and improve the quality of the services provided. This was evidenced by issues identified at this inspection.

People had been asked for their views about the service but these had not been acted upon.

Holly Bank 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.

This inspection took place on 1 June 2016 and was unannounced.

The inspection team consisted of two inspectors.

Before the inspection we reviewed the information we held about the service. This included speaking with the local authority contracts and safeguarding teams. We asked the provider to complete 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. This document was completed and returned to us.

On the day of our inspection we spoke with eight of the people who lived at Holly Bank Care Home, one night care worker, five care workers, housekeeper, deputy manager and the registered manager.

We spent time observing care in the lounge and dining room and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us. We looked around the building including bedrooms, bathrooms and communal areas. We also spent time looking at records, which included; eight people's care records, two staff recruitment files and records relating to the management of the service.

Inadequate

Our findings

People we spoke with told us at times they did not think that there were enough staff on duty to meet their needs. One person using the service said, "The biggest problem is getting to the to the toilet or commode in time. I use my buzzer but have to wait too long sometimes." A second person told us, "I have to wait too long to be taken to the toilet."

Although staff we spoke with said there were enough staff working in the home, we were not assured there were always sufficient numbers of staff deployed to meet people's needs at all times.

There were 22 people using the service when we inspected and accommodation was provided over four floors. The deputy manager told us the usual staffing levels were one senior care assistant and four care staff throughout the day and two care staff at night. These staffing levels were confirmed by staff we spoke with. An additional care staff member was deployed as a cook. The registered manager, deputy manager, administrator and housekeeper were also present during the day.

We looked at the staff duty rotas from 9 May 2016 to the day of the inspection. We were unable to determine from the rotas if the staffing levels stated by the deputy manager had been maintained. This was because not all staff working in the home were included on the rota. Staff roles were not always identified or the hours they worked. For example, the registered manager and deputy manager's hours were not included on the rota. Neither were the administrator's or maintenance person. The deputy manager told us one of the care staff was assigned to do the cooking each day yet this was not identified on the rota. Only the first names of night staff were recorded and the deputy manager told us some of these were agency staff although this was not reflected on the rota. The night staff hours were not recorded.

The deputy manager told us there were three people who were assessed as high dependency and required at times the support of two staff. This meant at night there would be no care staff available to other people if the night staff were assisting one of these three people. We asked the deputy manager how staffing levels were calculated and they were unable to explain how these numbers had been determined. The deputy manager told us they put extra staff on 'as and when needed' and said they had on occasions brought in extra staff to work from 2pm until 10pm or 4pm to 11.30pm to provide support to the night staff. This was not reflected on the duty rotas we saw.

Although people's dependencies were assessed and recorded the deputy manager acknowledged there was no tool used to calculate safe staffing levels within the home. We were not assured the staffing levels were

sufficient to meet people's needs and there was no evidence to show people's dependencies and the layout of the building had been taken into account to ensure staffing levels were safe.

This was a breach of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service told us they felt 'safe' living at Holly Bank Care Home. One person told us, "I feel safe here now that one person has moved out, because they used to go from room to room and it frightened me when they came into my bedroom." Another person said, "I feel safe here, it's a nice place." A third person told us, "I feel safe here, I couldn't manage at home."

We saw the glass panel in the front door was broken and had been boarded up. We asked a care worker about this and they told us someone who had since left the home had caused this damage. When we spoke to the registered manager they told us the person who had moved out had challenged the service and one night they had to call the police because they were unable to get the person to settle. They told us they had told the safeguarding team about these incidents, however, the safeguarding team and the Commission had no record of being informed about either incident.

Staff we spoke with told us they would report any concerns about people's wellbeing to a senior member of staff. We also saw abuse and indicators of abuse had been discussed at a staff meeting. We concluded the safeguarding procedures were not robust as safeguarding incidents had not been reported.

This was a breach of the Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found risk management processes needed to improve as following safety related incidents such as falls, there was insufficient information recorded to show how the provider was mitigating the risk of these incidents occurring again. For example, one person's records showed they had fallen in January 2016 and been taken to Accident & Emergency. There was no falls risk assessment recorded and nothing in the care plan to show how this person was kept safe. A further incident was recorded where it described another person's leg being stuck at the side of the bed and stated the bed rail was to be put up. Yet a risk assessment showed bed rails were unsuitable for this person as in the past they had tried to climb over them.

There were no nutritional risk assessments in place for two people whose records showed they had lost weight in recent months and no information in their care plans to show what action was being taken in response to the weight loss.

When we looked in people's care files we saw some risk assessments were being completed, however, these were not always accurate. For example, staff had completed a pressure ulcer risk assessment for one person, which identified they were not at risk of any tissue damage. However, the 'score' for the assessment had not been accurately completed and the correct score indicated the person was at medium risk of developing tissue damage.

We saw the pressure ulcer risk assessment document required staff to assess people's build for example average or ideal. However, as no nutritional assessments had been completed and there was no information about people's body mass index (BMI), it was unclear how staff were making this assessment. We saw one person had lost 12kgs in weight since October 2015 and they looked under weight, however, on their assessment staff had recorded they were of average/ideal weight.

We concluded appropriate action was not being taken to mitigate the risks to people using the service.

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

Some staff we spoke with were not clear about the fire procedures and had not taken part in a recent fire drill. We also found senior staff were not clear as to how many people were using the service. For example, two staff told us there were 23 people and a third told us there were 21, when there were actually 22 people using the service. These two factors combined with the fact that the duty rotas did not accurately reflect who was working in the home placed staff and people who used the service at risk.

When we looked at the care records we saw some people had 'personal emergency evacuation plans in place.' We asked the registered manager if copies of these were kept in a separate file, so that in an emergency this information could be found quickly. They told us this information was only available in the care files.

We asked staff what they would do if the fire alarms sounded. One said they would take people who used the service out to the car park, another said they would check to see if there was a fire and a third told us they would go to the fire panel to get instructions from the senior care worker on duty. We found some staff had not participated in a fire drill so were not familiar with the correct procedure.

We looked at the fire risk assessment for the home and saw this had been completed in 2011. We also noted there were only two care workers on duty at night to provide emergency support over all four floors of the home. We concluded the emergency procedures were not robust and did not ensure people's safety.

Following our inspection we asked the fire service to check the fire precautions at the home.

This breached Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We found medicines were not always stored securely or safely. The door to the clinical room where medicines were kept was secured by a bolt at the top of the door. Although the medicine trolley, which was kept in the clinical room, was locked and secured to the wall, the medicine fridge was unlocked and contained prescribed medicines. This meant people not authorised or trained in medicines management had access to prescribed medicines. We also found one person's medicines, which were being self-administered, were not kept securely as they were stored in an unlocked drawer in an unlocked bedroom. We found the daily recording of temperatures of the clinical room and medicine fridge had lapsed as the last entry was made in January 2016.

We looked at the provider's medicine policy which had been reviewed by the provider in February 2016. We found the policy lacked detail as some aspects of medicines management were not covered. For example, there was no information about covert medicines or guidance for staff about what to do if a person is asleep or having a meal. We discussed this with the provider and directed them to The National Institute for Health and Care Excellence (NICE) document 'Managing medicines in care homes' (March 2014).

The provider's medicine policy stated the medicine keys were to be kept in the possession of senior care staff at all times. The provider confirmed only senior care staff had been trained to administer and manage medicines. However, they confirmed at night there were no senior care staff on duty. We asked staff what would happen if people requested pain relief or other medicines overnight. One said the night care staff would give the medicines and another said the senior staff member on call would come in. However, both

staff told us the keys were left in the office overnight which meant untrained and unauthorised staff had access to people's medicines.

We looked at a sample of medicine administration records (MARs) and found overall they were well completed. However, we saw some gaps where staff had not signed the MAR yet our checks showed the medicines had been administered. There were individual photographs and information about allergies and how people liked to take their medicines was recorded. However, we saw three people had handwritten MARs with no photographs and found discrepancies in the recording. For example, we found one medicine contained in one person's dosette box was not recorded on the MAR. The amounts recorded for two other medicines had been transcribed incorrectly as the prescribed dose was in micrograms and the MAR stated milligrams. Although, no harm had been caused to the person as they had received their medicines as prescribed, it showed staff had not followed procedures when writing the MAR or administering the medicines as these errors had not been identified until we brought them to staff's attention.

The printed MARs contained information to guide staff as to when and how often to administer 'as required' medicines. However, we found further guidance was needed where people were unable to verbally communicate if they were in pain to ensure staff recognised non-verbal signs and responded accordingly. We saw times were recorded when 'as required' medicines had been offered and given as well as the number of tablets were the dose was variable. We checked the stock balances of two of these medicines and found they were correct.

Creams and ointments were stored in people's rooms and dated upon opening. However, we found the application of creams was not always recorded. The senior care staff member told us care staff completed the topical MARs, which were kept in people's bedrooms. We looked at the topical MARs for three people which commenced on 23 May 2016 and none had been completed.
This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations

We observed the senior care staff member for part of the morning medicine round. The staff member was calm and efficient and followed good practices to ensure medicines were administered safely. For example, the medicine trolley was locked between administration and the medicine administration record (MAR) was signed once the medicines had been taken. We saw the staff member was patient and kind with each person giving them support where needed and staying with them until the medicines had been taken. The senior staff member told us no one received their medicines covertly.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs (CD). We found these medicines were kept securely and records were completed correctly. We checked the stock balance of one CD and it was correct.

We looked at two staff files and found a robust recruitment procedure had been followed. Both had completed application forms, gaps in employment were checked and interview notes were recorded. We saw checks had been completed which included two written references and a criminal record check through the Disclosure and Barring Service (DBS). This helped to make sure people were protected from the risk of being cared for and supported by staff unsuitable to work with vulnerable adults.

We asked people if they liked the accommodation. One person told us, "I am quite comfortable here and they [staff] keep it clean and tidy." A second person said, "I love my bedroom it's spacious and I have brought my own furniture."

We looked around the building and found it clean, tidy and odour free. We spoke with the housekeeper who told us they did the cleaning and laundry. They told us on their days off other staff were put on the duty rota to cover these duties.

We found the building was well maintained. Communal areas were well decorated and comfortably furnished. There were 21 single bedrooms and two double bedrooms all of varying sizes and layout. Five bedrooms had en-suite toilets and 13 had en-suite toilets and showers.

We saw a range of checks were undertaken on the premises and equipment to help keep people safe. These included checks on the fire, electrical and gas systems.

We saw the food standards agency had inspected the kitchen in 2014 and had awarded them 4* for hygiene. This was the second highest rating which meant they found the hygiene level to be good.

Requires Improvement

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). DoLS requires care homes to make applications to the local authority where they suspect they are depriving people of their liberty.

The deputy manager told us there were two people had current DoLS authorisations and two other people who had recently used the service had had DoLS in place. However, there was no overall system to monitor the DoLS authorisations in place, the conditions attached or when they would expire. We found one of the DoLS which the deputy manager told us was in place had expired in March 2015. Although the deputy manager contacted the managing authority once we had brought this to their attention, they and the registered manager had been unaware the DoLS had expired. Staff we spoke with also believed a DoLS was in place for this person.

We saw the DoLS for one person who had recently left the service had three conditions. When we checked this person's care records we found no evidence to show these conditions had been met.

Staff we spoke with confirmed they had received training in MCA and DoLS. However, we found there was a lack of understanding of the legislation and poor recording around mental capacity assessments and decision making in the use of equipment that placed restrictions on people such as bed rails. At the morning handover night staff reported one person had been found crawling on their bedroom floor. This person's care plan indicated bed rails were in use and we saw these were fitted to their bed. However, there was nothing in their care plan to show how the decision to use bed rails had been made or that their use was in the person's best interest. We concluded the lack of staff understanding of the MCA and DoLS was placing people at risk of having unnecessary restrictions placed upon them.
This was a breach of the Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no evidence in the care records we reviewed to show people's care had been discussed with

them and that they had consented to the care and treatment provided. We saw one person had a 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) form dated January 2015 in place which was valid till the end of their life. The form stated the person had capacity and the DNACPR decision was against their wishes. There was no other information on the form to show why this decision had been made when the form clearly stated it was against the person's wishes. We were concerned this was not queried by the registered manager with the relevant health professional, although they stated they would do this when we brought it to their attention.
This was a breach of the Regulation 11of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they received the training they required to fulfil their roles and provide people with the care and support they needed. The majority of training was provided through e-learning and included subjects such as dementia, medication, safeguarding, infection control and fire safety. Moving and handling training was provided face to face by an external training provider. The training matrix showed training was mostly up to date and records we saw showed where training was overdue staff had been reminded and given timescales in which they had to complete it.

New staff received a local induction to the service which provided familiarisation with the service's policies and procedures and ways of working. It also included a period of shadowing more experienced staff, which one recently employed staff member told us had helped them to get to know people well. The deputy manager told us new staff were not required to complete the Care Certificate, although they said this was something they would be introducing. The Care Certificate provides care workers with standardised training which meets national standards.

Staff told us they received regular supervision and this was confirmed in the staff records we reviewed. We saw there was an annual planned programme of supervision for staff. We asked to see records of staff appraisals and the deputy manager told us there were none. They acknowledged that an appraisal system needed to be put in place to ensure staff performance and developmental needs were identified and addressed.

We asked people using the service about the meals. One person told us, "The meals are quite good, not like home." A second person said, "There is nothing wrong with the food." A third person told us, "The portions look a bit small, but they seem to be sufficient."

The registered manager did not employ a cook and told us they didnot plan to do so in the future. Some of the care workers took it in turns to prepare the meals. We looked at the two week menu which showed us there were choices available at mealtimes. However, when we looked at the residents' meeting minutes we saw people had asked for some specific choices to be added to the menus. For example, jacket potatoes and bread and butter pudding. Neither of these featured on the menus. We asked the registered manager about this and they told us these foods were provided but this could not be evidenced.

We saw sausages featured four times over the two week cycle of menus. We asked the deputy manager about this and they said this was because people using the service wanted them.

As soon as the day staff came on duty at 8am they began to serve people breakfast as they got up. We saw people were offered cereals, toast and a hot drink. No one was offered a cooked breakfast.

Prior to the lunchtime meal people were asked to choose between sausages or chicken in breadcrumbs. We saw the tables were set with cutlery, crockery, serviettes and condiments and people were offered a choice

of cold drinks with their meal. The sausages and chicken gougons were served with mashed or chipped potatoes, sweetcorn, Brussel sprouts and gravy followed by cherry pie. Hot drinks were served after the meal. The mealtime was a social occasion and people were talking to each other, whilst eating their meal.

We saw one person was having a soft diet and each component of the meal had been blended separately. However, the care worker who was offering assistance did not know what the meal consisted of and proceeded to mix all of the elements together.

We saw jugs of juice were available in the lounges. People told us mid morning and mid afternoon hot drinks were offered with biscuits. We asked people about supper and they told us this consisted of a hot drink and biscuits. We asked the registered manager about this as we did not think this was sufficient to sustain people until the next morning. They told us porridge was also available.

We would recommend the provider review their menu planning to ensure people are provided with a nutritionally balanced diet that meets people's specific needs and preferences.

Care records we reviewed showed people had access to a range of NHS services. They showed the involvement of GPs, district nurses, opticians and chiropodists. We saw the chiropodist was in attendance during the afternoon of our inspection.

Good

Our findings

We asked people using the service about the staff. One person told us, "The staff are extremely good, very nice, very polite and professional." A second person said, "I am very happy, you are looked after here. I get on well with the staff and you can have a laugh with them." A third person told us, "They [staff] are all very nice and do what they can for you. They help me with anything I need." A fourth person said, "It's a nice place, staff are fine." A fifth person commented, "I like it here. Yes I do." A sixth person said, "The staff are good. They look after you."

We witnessed some good humoured exchanges between people using the service and staff. For example, one of the care workers asked one person what they would like for breakfast. They replied, "Caviar!" The care worker then asked if they would like 'Champagne' to go with it. Both laughed and the person then settled for toast and coffee.

There was a friendly, relaxed atmosphere in the home and we saw staff were kind and caring in their interactions with people.

When we spoke with the registered manager and deputy manager it was clear they had a lot of knowledge about people's life experiences, personal preferences and interests. However, when we looked in the care files we found this information had not always been recorded. It is important for this information to be recorded so staff can provide person centred care.

We saw people looked clean, well groomed and comfortably dressed which showed staff took time to assist people with their personal care needs when required. People told us the laundry service was good and we saw people's clothing had been neatly put away in wardrobes and drawers.

We saw staff ensured people's privacy and dignity was respected. For example, asking people discreetly and quietly if they wanted to go to the toilet.

Two people told us their religious needs were met and they received Communion every week and were visited by their priest. A church service was also held at the home every month for those who wished to attend.

We did not meet any visitors during our inspection, however, people using the service told us their relatives and friends were always made to feel welcome and were offered a drink.

Requires Improvement

Our findings

We looked at people's care records and found these did not provided clear guidance for staff about the care and support people required or how they preferred this to be delivered. The records were not up to date and lacked personalised information. We found some records were not fully completed, did not have people's names on and others were not dated or only had the month recorded, not the day or year. We looked at the care records for two people who had been admitted for respite care and found a lack of information about their care needs and the support each person required from staff.

One person's weight records showed they had lost over 4kgs between January and April 2016, yet there was no nutritional risk assessment completed and nothing in the person's care plan to show what action had been taken in response to this. The care records showed this person was prone to urine infections and advised staff to 'promote fluids'. Yet there was no information to show what this person's daily fluid intake should be. There was no information to show this person's preferences such as when they liked to get up or go to bed, if they preferred a bath or shower and when they would like to have one or what they could do for themselves in terms of washing and dressing.

Another person's care records showed they had lost 5kgs between February and May 2016. Although the registered manager told us this weight loss was not of concern because the person was still a healthy weight, we were not able to determine this from the care records. There was no nutritional assessment recorded which meant the person's body mass index (BMI) had not been calculated to determine if the weight loss put the person at risk of malnutrition. The nutritional care plan made no reference to the weight loss.

We saw in one person's care records they were prone to constipation and had a urinary catheter. There was no care plan in place to inform staff how to care for the catheter. The care plan stated this person was at risk of developing urinary tract infections and needed to drink plenty. There was no guidance for staff about how much fluid they needed to drink every day. We looked at the records of their fluid intake over a 48 hour period. One day they had drunk 850mls and on the second day 950mls. We calculated they should have been having 1650mls of fluid every day. We also looked at the bowel chart and saw, according to the record they had only had their bowels opened once a week over a four week period. This showed us staff were not planning people's care and support to make sure their needs were being met. (Water for Health Hydration Best Practice Toolkit for Hospitals and Healthcare.)

We found some care records contained contradictory information. For example, one person had a

nutritional risk assessment which showed they were at high risk of malnutrition and their care plan stated they were to be weighed weekly. However, weight records showed the person was weighed monthly and had lost weight in the last five months. This person was assessed as at high risk of skin damage and was nursed on a pressure relieving mattress. We found the mattress was set to the highest setting and it was not clear from the care plan if this was the appropriate setting for this person's weight. We discussed this with the registered manager who said they would check this with the district nurses.

Daily records were poorly completed and did not reflect the care and support provided or how people had spent their days.

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

We asked people using the service if there were activities on offer to keep them occupied. One person told us, "There isn't much to do. We had a little sing-song this morning." A second person had a dog in their bedroom. They explained the deputy manager brought their dog in and they 'dog sat' and told us how much they enjoyed this. We saw a third person went out with the provider in their car and then for a walk with another member of staff. We also saw people reading newspapers, books and magazines.

The deputy manager explained most of the people who used the quiet lounge like to read and mostly were self sufficient in keeping themselves occupied. Staff told us they organised some activities such as sing-songs, card games, crafts and ball games. They also said entertainers came into the home and mentioned a band and a group of cheerleaders who had visited.

We asked people using the service what they would do if they were unhappy about anything in the home. One person told us, "I would tell them [staff] if something wasn't right." We saw the complaints procedure was on display in the hallway. The registered manager had received one written complaint which they had investigated and were in the process of responding to the complainant.

The deputy manager told us if anyone mentioned any concerns they were dealt with straight away, but not documented. This meant it was not possible to see if there were any emerging themes and trends, which might need to be addressed.

Inadequate

Our findings

The registered manager and deputy manager were not present for the handover between the night and day staff. The senior care assistant took the lead role for running and organising the shift. When we asked staff if the registered manager was on duty they told us they would be in later. The registered manager and deputy manager were not on the duty rotas so it was not possible to ascertain exactly how much time they were spending at the service.

When we spoke with staff we found them somewhat 'guarded' in their responses and they expressed concerns about 'saying the wrong thing' and 'getting into trouble'. We concluded there was not an open, honest and transparent culture in the home.

Prior to this inspection we contacted the local authority contracts team and they sent us a copy of their contract compliance report from their visit in November 2015. At that visit they identified the registered manager was not using any dependency tool to determine the number of care and support staff required to ensure that people's individual needs were being met. The contracts team sent the provider an example of a dependency tool following their visit. We found there was no dependency tool being used on our visit. This showed us the registered manager was not following guidance they had been provided with to ensure there were safe staffing levels.

We also saw as part of the contracts visit in November 2015 issues with the provider's governance systems had been identified. The report stated, "Since last monitoring in March 2015, little progress has been made in developing and embedding governance systems into the culture of management of the care home. Evidence could not be provided as to what audits are being undertaken by management, the frequency of auditing or the sample sizes being used. A discussion was held regarding the importance of having good governance systems in place and how this would help the care home achieve the CQC 'well led' criteria. It was felt that as things stood with governance within the care home, it would be likely that the 'well led' criteria would not be met at CQC inspection. By way of guidance, the Contract Performance Officer gave the Deputy Manager a copy of the governance audit tool they use for monitoring purposes." We found the registered manager had not acted on this advice as we found the quality systems in place were not effective.

We asked to see the quality assurance audits which were being completed.

We saw accidents were being listed on a monthly basis. However, the provider was unable to evidence this information had been analysed and used to look for patterns which could identify avoidable falls or injuries

in the future. For example, one person had four unwitnessed falls in one month and a further two the following month. No action had been identified on the audit or in their care plan to try and prevent any re-occurances.

We asked to see the care plan audits, however, these were not produced. There were no audits of people's weights to give a picture of the management of people's weights over time.

We looked at medicine audits which had last been completed in February and March 2016. These showed only some areas of the medicines management systems were checked such as stock levels and recording of medicine administration records. The records were not clear about the actions taken in response to the issues found, timescales or who was responsible for these. Issues we identified at this inspection had not been identified or addressed through the provider's audits.

During the inspection we found issues in a number of areas such as medicine management, safeguarding, Deprivation of Liberty Safeguards, planning of care, staffing levels. If there were effective systems in place all of the issues should have been identified by the provider and measures put in place to ensure they were rectified.

We saw people using the service and relatives had been given satisfaction surveys to complete in March 2016. We asked the deputy manager if they had provided people with feedback on the outcomes of the survey. They told us they were in the process of doing this. We saw people were generally very satisfied with the service but there were areas people felt could be improved. For example, two people who used the service and one relative said call bells were needed in the lounges. One person using the service said they waited too long for staff to answer their buzzer and another said their bed was uncomfortable. There was no evidence of any action being taken to address these issues.

We found the registered manager had been notifying us about deaths in the home and some safeguarding concerns, however, we had received no notifications regarding people who had DoLS authorisations in place. We asked to see the notifications file and saw the registered manager did not have the most recent CQC guidance and was working to the previous regulations. We showed them the CQC' Guidance for providers on meeting the regulations,' which was published in March 2015 and covered the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) (as amended). This document was sent to all to all providers, however, the registered manager and deputy manager told us they had not seen this document. This meant they were not working to the most current legislation.

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

We saw the environmental audits had identified areas for improvement, such as replacement carpets and redecoration. These audits were effective and reflected in the high standard of accommodation.

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 11 HSCA RA Regulations 2014 Need for consent The provider did not ensure care and treatment was provided with the consent of the relevant person. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not being operated effectively to investigate and report allegations of abuse. Service users were not protected from being deprived of their liberty. Regulation 13 (1) (3) (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons

were not deployed.
18(1)

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 12 HSCA RA Regulations 2014 Safe care and treatment Service users were not provided with care and treatment in a safe way as risks to their health and safety were not being assessed or plans made to mitigate those risks. The management of medicines was not safe and proper. 12(1) (2) (a) (b) (g)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established or operated effectively to assess, monitor and improve the quality of the services provided or to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. The provider did not act on the feedback they received from relevant persons. Regulation 17 (1) (2) (a) (b) (e).

The enforcement action we took:

warning notice