Larchwood Care Homes (North) Limited

Laureate Court

Inspection report

Wellgate
Rotherham
South Yorkshire
S60 2NX

Tel: 01709838278

Date of inspection visit:
16 November 2016
17 November 2016

Date of publication:
20 December 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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 took place on 16 and 17 November 2016 and was unannounced on the first day. This was the fourth rated inspection for this service which had previously been rated inadequate in June 2016 and was placed in special measures. You can read the report from our last inspections, by selecting the 'all reports' link for 'Laureate Court' on our website at www.cqc.org.uk.'

Laureate Court providers residential and nursing care for up to 82 people who are living with dementia and other mental health problems. The home has three units, Byron and Shelly both provide nursing care and Keats which provides residential care. The home is located close to Rotherham town centre. At the time of our inspection there were 48 people using the service, 20 people receiving nursing care and 28 people in receipt of residential care.

There had been recent changes in the way staff were deployed due to the temporary closure of the Byron unit. This was due to a planned refurbishment. Therefore there were only two out of three units open at the time of our inspection.

The service did not have a registered manager in post at the time of our inspection. 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. A manager had been appointed by the provider in January 2016. This person had left the service and another manager was in place who had commenced their employment with the organisation approximately four weeks prior to our inspection. This person was present throughout the inspection.

During this inspection we looked to see if improvements had been made and embedded in to practice from our last inspection. We found insufficient progress had been made. We identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Systems were in place to ensure people received their medications in a safe and timely way from staff who were appropriately trained. However, we identified some areas that could be further improved. People were not protected against the risks associated with infection prevention and control as safe procedures were not followed.

People who used the service, and their relatives we spoke with, told us they were happy with how care and support was provided at the home. All people we spoke with told us the staff were very good and they felt safe.

At our inspection of November 2016 we found improvements had been made in staffing levels and staff worked together better as a team. However, we found that the deployment of staff was not always effective to ensure people's needs were met.

We saw there were systems in place to protect people from the risk of harm. Staff we spoke with were knowledgeable about safeguarding people and were able to explain the procedures to follow should an allegation of abuse be made. Assessments identified risks to people and management plans to reduce the risks were in place to ensure people's safety.

Our observations showed most people were supported to eat and drink sufficient to maintain a balanced diet and adequate hydration. However documentation did not always support this and at times we saw some people were not adequately supported with their meals.

Staff told us they had not received regular supervision but felt supported with the new manager in post. Staff training had also been identified by the new manager as an area that required attention and they had arranged dates for training.

We saw evidence of involvement from health care professions when required. For example, we saw referrals to speech and language therapists when people presented with swallowing difficulties.

The service was a purpose built home but was in need of refurbishment. The environment was not well maintained or dementia friendly. The provider was aware of this and had a refurbishment plan. Since our last inspection in June 2016 the provider had closed one unit, Byron, in preparation for the refurbishments to take place.

People's needs had been assessed and most of the care files we checked reflected people's care and support needs choices and preferences. These were all in the process of being reviewed, updated and transferred to new paperwork at the time of our inspection.

The service had an activity co-ordinator who planned and organised social stimulation for people. This person had been on leave for four weeks. An additional activity co-ordinator had commenced employment the day of our inspection. This had an impact on the activities provided over the past few weeks

Complaints were dealt with in a timely manner and in line with the provider's policy and procedure. People who used the service felt they could approach staff if they had a concern.

Audits were in place to monitor the quality of service provision, however, they were not always effective and the Systems needed embedding in to practice.

The new manager had commenced meetings with staff and people who used the service and their relatives. However, these had only recently occurred since the new manager had been in post.

At the last comprehensive inspection this provider was placed into special measures by CQC. This inspection found that there was not enough improvement to take the provider out of special measures.

CQC is now considering the appropriate regulatory response to resolve the problems we found.

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.

People were not protected against the risks associated with infection prevention and control.

Our observations showed that staff worked together as a team. However, we found that the deployment of staff was not always effective to ensure people's needs were met.

Systems were in place to ensure people received their medications in a safe and timely way from staff who were appropriately trained. However, we identified some areas that could be further improved.

We saw there were systems in place to protect people from the risk of harm.

Risks associated with people's care had been identified.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff told us they had not received regular supervision but felt supported with the new manager in post.

Our observations showed that food and drink provided was sufficient to maintain a balanced diet and adequate hydration. However, The mealtime experience for some people did not provide an environment which supported them effectively to eat and ensure they received the food provided.

The new manager had arranged training to take place to ensure staff's knowledge was up to date.

People had access to health care professionals as required.

Is the service caring?

Requires Improvement

The service was not always caring.

We observed practice and found that staff were in the main caring. However, some observations particularly on Keats unit showed that care given was task focused.

We saw some personal information displayed on the outside of people's bedrooms. This did not maintain peoples confidentiality.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs had been assessed and most of the care files we checked reflected people's care and support needs choices and preferences.

Activities were provided to people. However, these were minimal during our inspection so people received lack of social stimulation.

Complaints were dealt with in an appropriate manner.

Is the service well-led?

Inadequate

The service was not well led.

We saw audits had been completed which did not always highlight the concerns we found on inspection.

The provider had failed to make sufficient improvements to address the concerns raised at our inspection in June 2016.

The new manager had commenced meetings with staff and people who used the service and their relatives to gain their views. These needed embedding in to practice.

Laureate 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 the 16 and 17 November 2016 and was unannounced on the first day. The inspection team consisted of 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.

Before our inspection, we reviewed all the information we held about the home. We spoke with the local authority to gain further information about the service.

We spoke with 10 people who used the service and 7 relatives, and spent time observing staff supporting with people.

We spoke with 12 staff including care workers, nurses, (including the deputy manager), ancillary staff, a cook, the manager and the regional manager. We looked at documentation relating to people who used the service, staff and the management of the service. We looked at eight people's care and support records, including the plans of their care. We saw the systems used to manage people's medication, including the storage and records kept. We also looked at the quality assurance systems to check if they were robust and identified areas for improvement.

Requires Improvement

Is the service safe?

Our findings

At our inspection of November 2014 and June 2016 we found issues relating to the management of medicines. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) 2014.

At our inspection of November 2016 we found some improvements, but also identified some similar concerns to those identified in June 2016.

We looked at the systems in place for managing medicines in the home. This included the storage, handling and stock of medicines and medication administration records (MARs).

We found medication storage rooms had air conditioning installed and this was set to 18 degrees centigrade. Temperatures were checked daily to determine they were maintained at the correct temperatures, this included the room and refrigerator temperatures. There was not a minimum and maximum thermometer to monitor the room temperature therefore, it was not possible to determine if the room had been maintained within the recommended temperature range over a 24 hour period.

We found staff who administered medicines recorded the amount of medicines received or the amount carried forward from the previous month. There were good records kept of the administered medicines and also when they were disposed of. This ensured the systems were safe and people received medication as prescribed. However, we found one person was regularly refusing to allow staff to administer their eye drops. The nurse we spoke with told us this had been ongoing for weeks. This had not been reviewed by the person's GP and no other options had been considered by the staff. This meant this person was not receiving their medication as prescribed.

We found people were prescribed medication to be taken as and when required known as PRN (as required) medicine. For example, for pain relief or to alleviate agitation. We found people did not always have PRN protocols in place. These protocols would detail when to give PRN medication and explain how people presented when they were in pain or agitated. For example, we found one person regularly presented with behaviour that challenged and was prescribed medication to help with this to be given when required. There was not a protocol in place to assist with the safe care and treatment of this person. Staff told us this person, who was prescribed these medications would not be able to tell them when they were agitated or anxious due to their medical conditions. This meant that people who used the service could be distressed or in pain and not have medication administered as staff did not know what signs to determine when it was required.

The Keats unit had changed systems for administering medication; they had introduced an electronic system. All staff had received training on the new system. The new manager told us they were hoping this would also be introduced on the other unit. However, we identified one person who should have been prescribed a new medication on 9 November, yet on 17 November when we were checking medication records, this had still not been administered. The staff told us this had not been followed up until 14

November and the GP stated they had not received the information to be able to prescribe. This was faxed on 15 November and the medication came into the service on 16 November. However, the new system showed it was still not in stock so had not been given. This meant the person had not been given medication as prescribed. The medication was to alleviate anxiety and agitation and this delay in receipt of the medication could have had a detrimental effect on the person.
We requested the manager and regional manager look into the shorfalls we identified. They assured us this would be followed up and actions taken to ensure people received medication as prescribed.

This was a breach of Regulation 12 (g) of The Health and Social Care Act 2008 (Regulated Activities) 2014. The provider did not always ensure that effective systems were in place to ensure people received their medicines in a safe way.

The medication in the home was administered by staff who had received training to administer medication. Staff told us they had received competency assessments as part of their induction.

At our inspection of November 2014 and June 2016 we found issues relating to staffing. This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) 2014. Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed appropriately to meet people's needs.

At our inspection of November 2016 we found some improvements had been made and staff worked together better as a team. However, we still found that the deployment of staff was not always effective to ensure people's needs were met.

We saw dependency assessment in plans of care that identified people's dependency needs. People were assessed as high, medium or low dependency.

Staff we spoke with told us there was predominantly enough staff on duty to meet people's needs. Although a number of staff told us they could do with more staff in the morning on Keats unit. Our observations identified people's needs were mostly met in a timely way and staff were present in communal areas. However, during our observations over breakfast on Keats unit, we saw two staff were administering medications and the other four staff were assisting people to wash and get dressed. There was no continued staff presence in the dining room. We observed that staff bought people in and gave them their breakfast then left to assist another person to get up. This left people without any support with their meal. We saw people throw drinks and bowls of cereal on the floor as they had no support. People also used the door in the dining room to access the smoke area. People left this door open and the room became very cold, people kept calling out, 'close the door' and 'Its freezing.' We closed the door as we observed that staff did not respond to these requests. This example demonstrated that deployment of staff did not always ensure people's needs were met and the care and support given was very task orientated.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) 2014. Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed appropriately to meet people's needs.

At the last inspection in June 2016 we identified infection control issues. At this inspection we found the standard of cleanliness had improved. However, there were still areas that had not been addressed to ensure they were able to be cleaned. The shower room was unable to be thoroughly cleaned as tiles were missing from the wall, the drain was stained with engrained dirt and the seal to the base of the toilet was also stained. The bath in the bathroom and the bath panel was damaged and not able to be cleaned

effectively. We found store rooms which had items stored on the floors and the floor covering was carpet this means they are unable to be kept clean.

We also identified the kitchenette serveries on each unit were poorly maintained and they were dirty. The sinks were stained brown, worktops were damaged and not kept clean, edges of the cupboard draws were encrusted in engrained dirt, the fridge seals contained food debris and one was badly damaged. We discussed this with the acting manager and the regional manager who agreed the environment needed attention. They were disappointed at the state of the kitchenettes and agreed to ensure staff were aware of who was responsible for cleaning these areas. On the second day of our inspection the standard of cleanliness in these areas had improved, but could not be thoroughly cleaned due to the damaged areas.

This was a breach of Regulation 12 (h) of The Health and Social Care Act 2008 (Regulated Activities) 2014. The provider did not always ensure that people were protected against the risks of infections.

Care plans we looked at identified risk associated with people's care and treatment. We saw people had risk assessments in place to manage these risks. For example, people who were at risk of falls had been assessed and where necessary had been referred to the falls team. We also saw that people had fire risk assessments in place including personal evacuation plans.

The staff we spoke with were knowledgeable on safeguarding and whistle blowing policies and procedures. Whistleblowing is one way in which a staff member can report suspected wrong doing at work, by telling someone they trust about their concerns. Staff we spoke with told us they would not hesitate to report any safeguarding concerns. They told us if they felt the management were not responding appropriately they would report to the local authority. Although some staff told us they were yet to attend training in safeguarding of vulnerable adults.

We spoke with the manager and they showed us safeguarding log which was in place. This detailed incidents of a safeguarding nature and gave information about what actions had been taken.

We spoke with relative's of people who used the service and they felt their relative's was safe living at the home. One relative said, "You just know they [their relative] are watched over. They are comfortable and content."

We looked at a selection of staff recruitment files and found the provider had a safe and effective system in place for employing new staff. The files we looked at contained pre-employment checks were obtained prior to new staff commencing employment. These included two references, and a satisfactory Disclosure and Barring Service (DBS) check. The DBS checks help employers make safer recruitment decisions in preventing unsuitable people from working with vulnerable people. This helped to reduce the risk of the registered provider employing a person who may be a risk to vulnerable people.

Staff we spoke with explained their recruitment process. They said they could not start work until they had received references and a satisfactory DBS check. Staff told us the induction was good. One staff member said, "I worked with another nurse during my induction to be able to understand my role and responsibilities." Staff we spoke with all said the training was improving but still had mandatory training to attend to ensure they were up to date.

Requires Improvement

Is the service effective?

Our findings

At our inspection of November 2014 and June 2016 we found the provider did not ensure that people who used the service were protected from the risk of inadequate nutrition and dehydration. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At our inspection of November 2016 we found some of the issues raised had been addressed but we also identified some areas for improvement.

We observed breakfast on Keats unit and breakfast and lunch on Shelley unit. People experienced a different meal time experience on each unit. The meal we observed on Shelley was pleasant; it was calm and people were chatting with staff and enjoying the experience. People were given choices of food and drink. Support was given in a sensitive and appropriate way. The breakfast we observed on Keats was very task orientated, there was no staff presence to offer support and it was chaotic and not a pleasant experience for people. We saw staff bought people into the dining room gave them breakfast then left. We saw one person throw their tea on the floor and another pick up the bowl of cereal try to put it to their mouth, but was unable to do this so had by accident tipped in onto the floor. Another person took a cup of tea that was not theirs and was drinking it when staff came in and realised and took it from them. The door to the garden was left open and the room became very cold. People kept saying, 'close the door.' Staff did not respond to this as they were not in the room, they did not even notice it was open when they came into the room.

People were served a cereal in a large plastic coloured bowl; we saw staff cover the cereal with milk. People struggled to eat this as it was a large amount of liquid. We saw one person trying to get a spoon full of milk to their mouth and their hand was shaking and the milk was spilling, they did this a few times and them gave up. No staff were present in the room to see this and offer support. The bowls also still had the sticky labels on from when they were purchased. The meal time on Keats was not a pleasant experience for the people who used the service. It did not provide an environment which supported people effectively to eat and ensure they received adequate nutrition.

There were no picture menus displayed on the Keats unit, to assist people to be able to make choices. People living with a diagnosis of dementia would have benefited from pictures to be able to make a choice. However, we saw menus on the Shelly unit were displayed on the tables and were available in picture format to assist people in making a choice of meal.

Tables were set with cloths, cutlery, serviettes and condiments. The meals provided appeared appetising, well presented and balanced. However, people received lack of support at meal times to ensure they received adequate nutrition and hydration.

We looked at care files belonging to people who used the service and found they contained food and fluid charts where appropriate. This was to record dietary intake. However, we saw that these were not very informative and did not state what the people had eaten or drunk in enough detail. For example, one chart

stated 'soup and sandwich, ate all.' This did not say what was on the sandwich and did not indicate how much had been given.

Staff we spoke with were knowledgeable on people's needs in regard to diet. Staff were aware of special diets, people's cultural needs and if they were at risk of choking. Staff had guidelines and assessments from dieticians and speech and language therapists to follow for individuals who were at risk to ensure the risk of choking was minimised. However, some people who were supported on keats unit were at risk of choking, therefore the lack of support on Keats unit put people at risk as staff were not present to assist and prevent choking. We observed one person was coughing constantly during their meal, but no staff gave assistance or questioned if they were alright. When we asked a member of staff if they were alright, they told us, "They always cough." They did go to the person and ask how they were or check their well being. We discussed this with the manager who told us they would address the deployment of staff on Keats Unit.

People we spoke with all told us the food was always very good. One person said, "It's lovely."

We saw that people were offered drinks and snacks during the morning and afternoon. This consisted of a selection of hot and cold drinks and snacks such as crisps, cake and biscuits. However, these were offered very close to meal times. For example, morning drinks were given at 11.30am and lunch was served at 12.30pm.

These examples demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014. The provider did not always ensure that people received appropriate support.

At our inspection of November 2014 and June 2016 we found that appropriate training, support, supervision and appraisal was not routinely carried out. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At our inspection of November 2016 we found some improvements had been made. However, these needed to be further embedded in to practice.

Staff told us they had not received regular supervision but felt supported with the new manager in post. However, they said this had only been over the last four weeks. They said it had been difficult without a consistent manager, but felt things were getting better at the time of our inspection. They acknowledged that they had felt like this previously when a new manager had started and then left but hoped this manager would stay. Staff said they supported each other and worked as a team.

We looked at supervision records and they showed that the new acting manager had commenced supervising staff. They told us they wanted to do the first supervision with all staff to get to know them and ensure they were aware of what was required to improve the service. The manager had covered training required and performance of staff as part the supervisions. This was to ensure staff were aware of the standards they were required to meet.They said they wanted staff to receive at least four supervisions a year they were hoping these would be up to date as well as staff appraisals by March 2017.

The new manager had reviewed training needs for staff and had arranged a large amount of training. This included moving and handling, Mental Capacity Act, swallowing awareness, silver level palliative care and behaviours that challenge others. Some of the training had already taken place and we saw that dates had been arranged for other training. Staff we spoke with were aware of what training they were to attend. One staff member told us, "I attended some training in December and it was very good, I really enjoyed it." The new manager told us they hoped all staff would be up to date with all training by the end of January 2017.

Care plans we looked at detailed people's needs and how they were met. We saw evidence of involvement from health care professions when required. For example, we saw referrals to speech and language therapists when people presented with swallowing difficulties and referrals to dieticians where people had lost weight.

The service was a purpose built home, but was in need of refurbishment. The environment was not well maintained or dementia friendly. The provider was aware of this and had a refurbishment plan. Since our last inspection in June 2016 the provider had closed one unit in preparation for the refurbishments to take place.

The environment was not well maintained or dementia friendly. The environment was very plain all painted one colour and in a poor state of repair. There was no dementia friendly info available for people, for example there was no picture menus on Keats unit to assist people to be able to make choices. Notices boards with date and weather had wrong info on gave incorrect date.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014. People were not always cared for in a person centred way.

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 are called the Deprivation of Liberty Safeguards (DoLS). We saw evidence that DoLS applications had been submitted to the local supervisory body although most were still waiting for a response.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the service to be meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The staff we spoke with had a basic understanding and knowledge of this. Although staff told us they would like more training to better understand the MCA and DoLS.

Requires Improvement

Is the service caring?

Our findings

We spoke with people who used the service and their relatives. One relative said, "I consider my relative well cared for. I have never had any concerns." Another relative said, "Although communication is better than it was, I'm not sure how much information is passed on at handover. I think there is still room for improvement when sharing information." Another relative said, "They [the staff] are good at spotting triggers that cause our relative to get agitated, such as when it gets noisy/busy in the lounge. At such times our relative is brought back to the calming area of their bedroom where favourite music is played until they're quiet again. I consider our relative to be well cared for and we have no concerns."

During our visit we spent time in communal areas observing people who used the service and talking with relatives and staff. We saw many positive interactions between people and staff. Although we did also see some very task orientated actions between staff and people who used the service. For example, meals were placed in front of people with no explanation and then they were left without support or assistance.

On the Shelley unit we saw staff supporting people in a caring and responsive manner while assisting them to go about their daily lives. We observed most staff treating each person as an individual and involving them in making decisions. We saw people were usually asked what they wanted to do or what assistance they needed in an inclusive sensitive way. For example, one person who required the use of a hoist, was offered appropriate support. We saw staff spoke with the person and explained what they were doing and they covered the person's legs with a blanket to preserve their dignity.

Another example was observed during lunch on Shelley unit. One carer recognised that a person preferred to sit in their wheelchair at lunch time, but as the person was quite short the table was too high. The carer fetched in to the dining room a smaller table so the person was able to sit at the correct height. This made a better dining experience for the person.

We also observed staff explaining to people what they were doing and offering choices. For example, when drinks and snacks were offered staff gave choices and respected people's decisions. However, from our observations on the Keats unit we found some support was very task orientated and the meal time experiences were not pleasant for people who used the service. Staff deployment oversights meant that staff had to work in a task orientated manner to be able to attend to people's personal care needs as a priority.

People's needs and preferences were being recorded in their care records in the new care files. We saw care plans included information such as their preferred name and cultural requirements. Information also included a life history section which gave a picture of the person's previous jobs, school, hobbies and interests and social life.

We found some personal information was displayed outside peoples rooms. We spoke with the new manager about this information. This was a document called, 'this is me.' This held confidential information such as date of birth. The new manager told us they had already noted this and would be moving the information to preserve confidentiality.

Requires Improvement

Is the service responsive?

Our findings

At our inspection of November 2014 and June 2016 we found the provider did not ensure that people received care that was person centred. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At our inspection of November 2016 we found improvements had been made. However, these require embedding in to practice.

We looked at eight people's care records in detail who used the service at the time of the inspection. We found that care plans had been reviewed and identified people's needs. These were in the process of being changed at the time of our inspection onto a new format that was more person centred in its approach.

The care plans informed staff how to support and care for people to ensure that they received care in the way they had been assessed. Regular reviews of care plans had been implemented to ensure that they were up to date and captured any changing needs. This had been introduced in a more meaningful way by the new manager and so most people had only had one review that was responsive to their needs. For example, we saw people who were at risk of poor nutritional intake were monitored and their weight was checked weekly. Where people had lost weight referrals to the appropriate health care professionals had been completed and there were good records of the outcomes of the visits conducted to ensure people's needs were met. However, measures that were put in place to monitor the care needs of people were not effective. We saw staff were required to complete food and fluid charts to be able to determine people were receiving adequate nutrition and hydration. We found these charts were not completed appropriately. They recorded only that the the person had eaten either all, half, quarter or three quarters of the meal but the amount served was not recorded so not able to determine how much was eaten. We also found many had not been completed for meals and they were left blank. These forms were not reviewed or evaluated and so the provider could not demonstrate how they both monitored care in this respect or responded effectively to any changes in people's needs.

For example one person's care plan we looked at had identified nutrition as a care need that they required assistance and support to be able to receive adequate nutrition. We observed this person was very agitated and did not receive support from staff when they were given a meal. Staff were monitoring this persons weight and they had lost 1.35kgs from 6 to 13 November 2016. This was clearly recorded and was on first line treatment plan, which included monitoring what they ate but the charts were not fully completed or reviewed. Therefore although people's care needs had been identified staff were not responding to actions implemented to ensure these needs were monitored and any changes idenitfed.

We spoke with relative's of people who used the service and one relative said, "We are not really involved in their [relative's] care plan." Another relative said, "I know they know about [my relative] and know about me too….they do listen to me. The staff on this unit are very good and caring to both of us… a happy ship."

People had access to social stimulation, however, the activity co-ordinator was on leave at the time of our

inspection. Some events such movement to music and church service had been arranged. We saw an activity display board which indicated an activity schedule. However, this was not being followed due to the activity co-ordinator being on leave. We did see some staff interacting with people, but some people were only given attention when a task needed to be completed. Therefore people received lack of social stimulation.

We spoke with the new manager and were told that an activity co-ordinator had commenced employment at the home on the first day of our inspection. This person will be in addition to the existing activity co-ordinator.

We spoke with people who used the service and their relatives and they spoke highly of the activities provided. One person said, "There is always something going on." However, one person said, "It's boring, there is nothing to do." One relative felt they, "Could do more entertaining, very rare they do anything, just TV on in background but no real entertainment." A relative told us that they felt staff would, "Bend over backwards to accommodate our wishes." They asked if they could bring in the family dog and were happy that permission was granted. They said that activities included musical afternoons and a visit to Yorkshire Wildlife Park.

At our inspection of November 2014 and June 2016 we found there were no evidence that complaints received were responded to in an appropriate and timely manner. This was a breach of Regulation 16 (1) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At our inspection of November 2016 we found improvements had been made. However, these require embedding in to practice.

We spoke with the new manager about complaints and how they were dealt with. We were shown a log which was in place to record any complaint and action taken. There had been one complaint since the new manager commenced in post and this had been resolved effectively.

We spoke with people who used the service and their relatives and they told us they would raise concerns with the staff or the manager. They told us they found the new manager approachable.

Inadequate

Is the service well-led?

Our findings

At our inspection of November 2014 and June 2016 we found the provider did not assess and monitor the quality of service provision. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At our inspection of November 2016 we found that insufficient improvements had been made since our last inspection. However we found since the new manager had been in post, they had identified and implemented improvments which had positively impacted on the services provided.

Staff we spoke with felt they worked well as a team and supported each other. They acknowledged that the new acting manager had improved the service in the four weeks they had been in post. However, staff had seen managers come and go over the last year so were concerned that this manager would stay and continue the improvements. We spoke with relatives who shared these anxieties. The new manager was in the process of registering with the Care Quality Commission.

We spoke with people who used the service and their relatives and one person told us that they were unsure now who the manager was. A relative said, The managers are never here long enough to get to know them." They were unaware of who the manager was at present. However, another relative told us that they knew who the new manager was and felt they had made a lot of progress in a short time. They said, "We just hope this manager stays, we have had so many changes."

There had been recent changes in the way staff were deployed due to the temporary closure of the Byron unit. This was due to a planned refurbishment. There were only two out of three units open at the time of our inspection. Therefore we did not see the service fully operating as at previous inspections. The new manager was due to meet with the architect at the end of November to discuss potential layout of the home.

The new manager told us that their main priority had been working with staff to provide better support for people, particularly on Shelly unit. The new manager had spent a lot of time on this unit and this was evident. However, Keats unit had not improved since our inspection in June 2016 even though the unit had a team manager and senior staff to support it.

At this visit we found systems to monitor the safety and quality of services had been put in place but were not always effective. For example, although audits had been completed, none of them identified that the kitchenettes were dirty. We found an infection control audit which had been completed in October 2016, highlighted that the bathroom on Keats unit was not clean. It had flaking paint and needed attention to the hand basin. This had not been addressed and was identified on out inspection. People were still using this bathroom regularly.

We found the new manager had implemented some audits, for example the pressure cushion audit and action had been taken. A health and safety audit had been completed in September by the provider and was

rated as a 'fail.' This identified issues raised on our last inspection which had not been addressed. For example, moving and handling training and fire prevention training was out of date and personal emergency evacuation plans were only partially completed. This was address following the audit by the new manager.

Since our last inspection we saw evidence that the provider (regional manager) had conducted special measures visits to check progress. These took place on 15 July, 20 July and 17 August. A home visit had been completed in November which highlighted that toilets needed cleaning and there was a slight malodour on Keats unit. But overall this was recorded as being a good visit.

During our inspection of November 2016 we found that problems had continued in relation to staff deployment. This led to staff being task focused on Keats unit and therefore not providing personalised care and support to people. This had not been identified as a concern and therefore no actions were in place to address this.

Following our last inspection we received weekly action plans from the provider stating what actions had been taken. People we spoke with had seen significant improvements since the new manager had commenced employment. However, systems and processes required further improvements and embedding in to practice.

This was a breach of Regulation 17 of the Health and Social Care Act 2008, Regulated Activities 2014. The systems in place for monitoring the quality and safety of the service were not effective.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not always cared for in a person centred way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not always ensure that effective systems were in place to ensure people received their medicines in a safe way. The provider did not always ensure that people were protected against the risks of infections.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place for monitoring the quality and safety of the service were not effective.

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 staff were not deployed appropriately to meet people's needs.