Eldercare (Halifax) Limited

Bankfield Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

Bankfield Care Home is registered to provide accommodation and personal care for up to 37 older people. Bedrooms are mostly ensuite and are set over two floors. There are two lounges, one split into two parts, and a dining room on the ground floor. On the day of the inspection there were 22 people living at the home.

At the last inspection in December 2015 we rated the provider 'Requires Improvement' and found one breach of regulation. At this inspection we found significant improvements had not been made and the service was still in breach of this regulation plus an additional two regulations.

A registered manager was not in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.' A new manager had recently been appointed who intended to begin the registered manager application process in the near future.

People and relatives we spoke with said they felt safe in the home and they thought the home provided good quality care.

Most people had updated risk assessments in place demonstrating risks to their health and safety had been assessed. However we found in some instances risk assessments were not up-to-date and saw examples of care plans not being followed by staff.

Overall medicines were safely managed, although some improvements were needed to ensure medicines were consistently managed in an appropriate way.

We concluded there were sufficient staff deployed to ensure people received prompt and safe care. Safe recruitment procedures were in place to help ensure staff were of suitable character to work with vulnerable people.

The premises was well maintained and safely managed with adequate communal space for people to spend time.

People and relatives spoke positively about the food provided by the home. People's nutritional needs were assessed and action was taken when people lost weight. However kitchen staff were not always fully aware of people's individual needs and preferences.

The service had made Deprivation of Liberty Safeguards (DoLS) applications for those it suspected were being deprived of their liberty. However care documentation was not sufficiently robust to evidence the service was fully acting within the legal framework of the Mental Capacity Act 2005 (MCA)

People had access to a range of health professionals and when appropriate, the service referred people to these professionals in a timely way.

Staff received a range of training to help ensure they had the skills to care for people effectively. Most training was up-to-date with a plan in place to address any expired training.

People and relatives told us staff treated them with kindness and compassion. Our observations of care and support confirmed this. People's views were listened to and their choices respected by staff.

People and relatives spoke positively about the overall standard of care provided. We saw some good person centred care plans in place, although some care plans were not up-to-date and did not reflect people's current needs. We also saw some instances where staff were not following the required plan of care, demonstrating people's care needs were not always met.

People and relatives provided mixed feedback about the activities on offer at the home with some people stating they would like more to do. An activities co-ordinator had been recently employed and we saw evidence they were in the process of improving the activity provision for people.

A system was in place to log, investigate and respond to complaints. People and relatives told us they felt comfortable raising complaints.

The service continued to be in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations. This should have been prevented through the operation of robust systems to assess, monitor and improve the service. We were also concerned about the high turnover of management within the organisation.

People and staff told us that there was a positive atmosphere within the home and they felt able to raise any queries or concerns with the management team.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations. You can see what action we asked the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

We identified some safety concerns where care plans had not been followed.

Overall we found most people received their medicines as prescribed although some attention was required to some areas to ensure medicines were consistently managed in an appropriate way.

We found there were enough staff deployed to ensure people received appropriate care and support and recruitment procedures were safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Improvements were needed to documentation to ensure the service could fully evidence that it was working within the legal framework of the Mental Capacity Act 2005 (MCA).

People had access to a choice of foods. However kitchen staff were not fully aware of people's individual needs and preferences.

People's healthcare needs were assessed. People had access to a range of health professionals and appropriate referrals took place when people's needs changed.

Is the service caring?

Good

The service was caring.

Overall people were treated with kindness and compassion and their dignity maintained by staff. People and relatives spoke positively about staff attitudes and said staff had a caring nature.

People were listened to and their choices were respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

We saw some instances where care plans were not followed by staff. Some care records also needed updating to demonstrate a full assessment of people's needs had taken place.

A system was in place to log, investigate and respond to complaints.

An activities co-ordinator was employed and people were provided with a programme of activities.

Is the service well-led?

Inadequate

The service was not well led.

Systems had not been operated effectively to improve the service following our previous inspection in 2015 with three breaches of regulation identified.
We were concerned about the high turnover of management within the provider.

People and relatives spoke positively about the management team and said there was a good atmosphere within the home.

Bankfield 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 look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. We also checked to see whether improvements had been made to the home following our previous inspection in May 2015 where a breach of regulation was identified.

The inspection took place on 8 December 2016 and was unannounced. 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.

We used a number of different methods to help us understand the experiences of people who used the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at five people's care records, staff files and records relating to the management of the service. We spoke with six people who used the service, four relatives, three care workers, the cook, the activities co-ordinator, the interim manager, the new manager and the compliance manager. We also spoke with one health professional who has experience of the service.

We reviewed all information we held about the provider and contacted the local authority to get their views on the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at Bankfield. For example, two people who were sitting together both described, "feeling happy enough," and "we feel safe here." Relatives also told us they thought people were safe. One relative said, "I feel very happy with the care [person] receives here."

Staff demonstrated they knew how to identify and report any allegations of abuse. Staff received training in safeguarding and had their competency assessed as part of the recruitment and induction process. Staff told us they thought people were safe in the home and did not raise any concerns with us about the way people were treated. They said they would be happy for their relatives to live in the home. We saw appropriate liaison had taken place with the local authority regarding incidents that met the locally agreed safeguarding referral criteria such as falls.

Incidents and accidents were recorded, investigated and action taken to learn from incidents. Following incidents such as falls, measures were put in place to prevent a re-occurrence and risk assessments were updated.

In most care records we saw appropriate risk assessments in place to ensure people were kept safe and to mitigate risks. These included moving and handling, falls, nutrition, skin integrity and infection control. Some had been recently updated and the interim manager told us they were reviewing all the risk assessments to ensure these were up to date and relevant. We saw some risk assessments had been signed by the person or their relative and others had not.

However during observations of care and support we observed some safety concerns. We saw one person helping a second person to mobilise using an under-arm lift with both people becoming unsteady. Once both people had stood up a staff member observed the situation and intervened, assisting the second person to the toilet; however they did this using the first person's mobility frame. This meant the first person's mobility was compromised and they had to return to their seat without their walking frame. We saw although the second person did have a mobility frame it had been stored away in a room out of reach. In addition, whilst the second person had an updated mobility risk assessment in place, their moving and handling care plan had not been updated and did not reflect their current mobility needs. There was also no mention of the risk associated with the person being assisting by the other person which staff told us was a regular occurrence.

During observations of care and support we saw one person refused to eat their main meal and only ate a dessert. When we asked a member of staff about the person's dietary habits they informed us that this person usually, "never had a main meal," and ate a lot of sweets, desserts and chocolate drinks. However when we looked at this person's care plan it was very basic, stating they were diabetic, needed low calorie meals and made no reference to not eating main courses or eating mostly sweet things. There was therefore a discrepancy between the care plan and what staff were telling us. We looked at the person's recorded food intake which showed they consumed a large amount of high calorie drinks and desserts which would likely have a high sugar content. When we spoke with the cook they were unaware this person

was diabetic. Although we were told the person had capacity to make decisions relating to their diet, our observations of practice, discussions with staff and review of food diaries did not provide us with adequate assurance that staff were encouraging the person to eat a well-balanced and healthy diet in line with their plan of care. Following the inspection, the manager undertook a review of this person's eating and drinking plan of care to help mitigate the risks we identified.
In addition, one person's falls risk assessment stated they should sit on a falls sensor mat whilst sitting in the lounge. We observed this was not in place during the inspection. We raised this with the senior care staff who said they would ensure a sensor was provided in line with their plan of care.

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

Overall we found medicines were safely managed but some improvements were required to ensure they were consistently given in an appropriate way. Senior staff administered medicines, had undertaken medicines management training and their competency to safely administer assessed.

We observed the medicines round and saw the senior care worker was kind and pleasant with people asking consent before administering medicines and allowing people to take their medicines in their own time.

Medicine Administration Records (MAR) were consistently completed indicating people had received their medicines as prescribed. The number of tablets administered was recorded on the MAR as well as the stock balance ensuring all medicines were accounted for. We undertook a random stock check of medicines and found the number in stock matched with what should have been present if people had consistently received their medicines as prescribed. Some people were prescribed medicines to be given before food. However we saw these medicines were routinely given with breakfast which meant they were not being given in line with the prescriber's instructions.

We identified one isolated instance where the service should have been more responsive to a person's refusal to take their medicines. We saw one person had been prescribed eye drops for a long term eye condition. However, when we checked the medicines administration chart (MAR) we saw these had been missed for a 15 day period. We were concerned this had occurred over a sustained period of time with no GP referral and the possible effects of missing this medication had not been taken into consideration.

It is important to ensure some medicines for the treatment of pain are given at least four hours apart. On reviewing MAR charts for these types of medicines, the times of administration had been pre-printed by the pharmacy for 09.00 and 12.00. Although we did not seen any evidence they were strictly given at these times, this highlighted the need to ensure the service could evidence appropriate time intervals between doses.

Where people were prescribed topical medicines such as creams we saw body maps were in place to instruct staff exactly where to apply these creams. Records were consistently completed indicating people had received these creams when they needed them. Where people were prescribed nutritional supplements to increase their nutritional intake these were given consistently each day.

Some prescription medicines contain drugs controlled under the misuse of drugs legislation. These medicines are called controlled drugs. We found these medicines were managed safely and robustly accounted for.

Some people were prescribed 'as required' medicines. The senior care worker administering medicines had a good understanding of when to offer these medicines. We saw in most cases protocols were in place

detailing when these medicines should be given although this was not always the case.

Appropriate secure storage arrangements were in place for medicines and the temperatures of the storage room and fridge were regularly recorded. However we noted on the day of the inspection the temperature in the storage room was slightly above the recommended storage temperature of 25C stipulated for many medicines.

We looked around the home and found the premises to be safely managed. There was a choice of communal areas for people to spend time including three distinct lounge areas, a conservatory and dining room as well as a hairdressing room. We saw safety features were in place such as guarded radiators to protect from the risk of burns. Window restrictors were in place and access to staircases restricted to reduce the risk of falls. The home was kept warm and pleasantly maintained with rooms personalised. Overall, we found maintenance was undertaken in a timely way. A maintenance worker was employed to undertake minor repairs and ensure the building was regularly checked for defects. However we did identify one window in the lounge was permanently open as the latch was broken, resulting in a cold draft. We raised this with the management team who said they had problems sourcing a repairer for the bespoke window but this had now been found and was due to be repaired in the near future. Checks took place on the premises and equipment to help ensure it was maintained in safe working order. These included the electrical, gas, fire and water systems as well as equipment such as the nurse call system and hoists. Personal evacuation plans were in place for each person providing information on how to safely mobilise people in the event of a fire or other emergency.

We found bedrooms to be clean and hygienic with no offensive odours detected throughout the home. However some of the communal areas such as the lounges had some stained and dirty equipment or furnishings. We noticed several large cobwebs in the dining area around the central light, as well as in the corners above the pelmet.

Overall we concluded there were sufficient quantities of staff to keep people safe. Most people and relatives told us staffing levels were sufficient. One relative told us, "There's always been plenty of staff." However one relative told us staffing levels were not always adequate and this had resulted in a delay in toileting for some people. During the morning one senior care worker and four care workers worked on shift, reducing to one senior care worker and three care workers during the evening, and two care workers overnight . During observations of care and support, overall we found there were enough staff to ensure people received prompt care and support when they needed it. However at times we found the staff team could have been better organised; for example at one point in the afternoon all staff were completing care documentation at the same time resulting in a lack of interaction with people who used the service. Staff we spoke with told us they thought staffing levels were adequate based on the needs of people living in the home. One staff member said, "Enough staff, no problems with that."

At the time of the inspection, agency staff were being used to cover some care workers shifts. The same agency workers were utilised where possible to ensure continuity of care. We saw plans were in place to recruit an additional three care workers to reduce agency usage. Ancillary staff such as cooks, maintenance workers, domestics and an activities co-ordinator were also employed.

Safe recruitment procedures were in place. Records showed appropriate checks and references were taken up before staff members began work. These included Disclosure and Barring Service (DBS) checks and proof of people's right to work in the UK. References from previous employers were requested and verified by management. Applicants for posts were required to provide complete work histories and any gaps in employment had to be explained. Any previous qualifications were checked. We saw head office regularly

audited recruitment records and asked the home's management to provide any additional information as required; this gave us
assurance that any discrepancies in recruitment documentation would be quickly identified and rectified.

Requires Improvement

Is the service effective?

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. In the case of a residential home a Deprivation of Liberty Safeguards (DoLS) must be in place. The Care Quality Commission is required by law to monitor the use of Deprivation of Liberty Safeguards (DoLS). DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control. Appropriate DoLS authorisations had been made for people the service had identified were likely to have their liberty deprived.

We also found where the supervisory body had put conditions in place as part of DoLS authorisations, some people's care plans had been developed to ensure these conditions were met and evidence of this clearly documented. For example, one person's conditions included regular review with the district nurse about the need for bed rest and for this to be recorded. We saw plans were in place to monitor and document this. However, we saw another person's DoLS conditions had included completing a Mental Capacity Assessment and best interest's decision around the use of a reclining chair, including consideration of Occupational Therapy involvement to assist/advise; this had not been done, despite the DoLS having been granted in May 2016. We discussed this with the interim manager and saw they put actions in place to rectify this immediately.

In other cases where people had monitoring devices such as sensor mats we saw no evidence recorded that people had consented to these or they had been provided as part of a best interest decision.

We recommend the service reviews its working practices to ensure it can fully evidence that it is working within the legal framework of the Mental Capacity Act.

People's consent was gained before helping with care and support and people were offered choices as to where they sat and what they did. For example, one person did not wish to sit in a chair but to remain in a wheelchair. This was respected and a cushion provided for the person to sit on to ensure easier access to the table. People were offered clothing protectors to wear at meal times and their choice was respected as to whether they wore one or not.

Staff we spoke with said they felt they received good quality training which gave them the skills required to meet the needs of the people they were caring for. For example, staff had completed dementia awareness training and told us they now felt more confident in caring with people living with dementia. New staff were subject to robust induction training arrangements. This included a range of role specific training such as Mental Capacity Act (MCA), tissue viability, safeguarding, dementia and manual handling. This was provided

through a mixture of face to face training and computer based learning. New staff without previous experience were also required to complete the Care Certificate. The Care Certificate is a government backed training scheme for staff in social care to ensure they achieve a broad knowledge and skill base. New staff also received a local induction to the service, its policies and ways of working. The service also supported new and existing staff to achieve national qualifications in health and social care.

Staff received regular training updates in relevant training topics. We looked at the service's training matrix and saw staff training was largely up-to-date although some updates were overdue. Where training had expired we saw a plan was in place to address with training sessions booked over the coming weeks.

Staff received regular supervision and appraisal where they had the opportunity to discuss any concerns and their work practice was evaluated. Staff said they were very happy working at the home and that there was, "good team support" for each other.

There was a choice of foods available to people at each meal. Menus were seasonal, on a four week rota and most of the food was freshly prepared and cooked. A pictorial menu was on display which provided people with information on what food was on offer at each meal. The dining area was well lit, with space to allow those residents to mobilise independently to the table, without apparent difficulty, using walking frames, or in a wheelchair. Tables were appropriately set and looked attractive. Breakfast consisted of a range of cereals, toast and the option of a cooked breakfast. People were offered the main meal of the day at lunchtime with a hot dessert, followed by a mid-afternoon snack of tea and cakes, and a range of sandwiches at teatime.

We observed the lunchtime meal and saw people appeared to enjoy the food. The dining experience was relaxed and people were not hurried to finish their food. However, we saw one person ate their vegetables and left the meat and their plate was taken away without them being offered an alternative. They were overheard telling staff they didn't eat meat. However, when we spoke with the cook they were unaware anyone preferred vegetarian food.

We saw people were offered hot and cold drinks throughout the day although there was a lack of water offered to people despite water being available in the corridor areas. This meant water was less accessible for those who were unable to mobilise independently.

We spoke with the cook who told us they fortified all foods with butter, cream and whole milk. We asked them about any specific dietary requirements and they told us some people were diabetic. However, they were unsure if they offered all diabetics a diabetic diet and were only able to tell us about one person for whom they had stocked diabetic ice cream and made separate custard. We did not see any information displayed in the kitchen with people's dietary requirements. We spoke with the interim manager who told us nutritional charts used to be displayed and they would ensure these were reinstated. They said they would speak with the cook to ensure people were receiving the appropriate dietary requirements.

People's weights were regularly monitored and we saw where people were assessed to be at nutritional risk, food and fluid charts had been completed appropriately, people had been referred to the dietician and nutritional supplements put in place.

We saw people's health care needs were supported with regular visits from health care professionals where required. For example, on the day of our inspection, we saw a district nurse visiting a number of people living in the home. They told us they visited twice weekly depending on need and told us, "They're very good at communicating. Will see me when I come and write down what I've done." We saw in people's care

records information about visits from their GP, podiatrist, district nurse team, optician, physiotherapist and community matron.

Good

Is the service caring?

Our findings

Overall people and relatives spoke positively about their experience in the home and said they were treated well by kind and caring staff. One person told us they, "feel very happy here," and there was, "nothing to improve." Another person stated, "I feel happy enough and the food is good and there is nothing to improve." A relative we spoke to stated they were, "very happy," with their relatives care. One person commented about the staff, "You couldn't get any better. We know one another. I wouldn't want to live anywhere else. There's some right good ones." A relative told us, "The care's been better than I expected. The staff are very helpful. The girls are lovely with [person]." They gave us an example of staff offering to move their relative's chair into a quieter area since they had initially found it noisy when they first moved into the home. This showed us staff were aware of the need to make people feel comfortable and relaxed in the home.

During observations of care we saw staff were kind and compassionate with people living at the home. For example, we heard staff gently guiding a person towards and armchair, using clear directions and encouraging language. They also told the person, "You sit wherever you like." This showed us people's independence and personal preferences were being encouraged. People appeared relaxed and comfortable in the company of staff. Care interactions between people and staff were generally positive with staff displaying a caring attitude and patience towards the people they were supporting. Staff checked people regularly to ensure they were feeling okay and used compassion and friendliness to calm any distress. For example, one resident became distressed and called to be moved away from the window area where she was seated because of the breeze as she felt cold and staff responded. However, we noted another occasion where two staff members assisted a person from an armchair into a wheelchair. They attached the transfer belt around the person without explaining what they were doing and were talking with each other about how to execute the move which was not respectful towards the person. We raised this with the management team during feedback who said they would look at interactions and address with staff involved.

People appeared clean and tidy with clothing in good condition. This indicated their personal care needs were being met by the service. A visiting healthcare professional commented, "I think they treat people with dignity and respect." They also told us, "The overall standard of care is good. They know how to deal with different people and judging how to deal with different people. They are very good at respecting people's wishes."

Care records contained personalised information on people's individual needs and preferences including information on life histories. This showed that the service had taken the time to learn about people to aid in the provision of person centred care.

People's privacy was respected. For example, people's clothing was adjusted by staff and they knocked on doors before entering. People were offered clothing protectors and some people had plate guards to make the dining experience more dignified.

We observed people were supported to maintain their independence where possible. This was considered

during the care planning process. People who could mobilise independently were encouraged to do so, for example seating themselves at the dining table at their own pace.

We saw people were offered choices as to how they spent their time, with staff listening to their requests regarding where they wanted to sit and what they wanted to do. Two people we observed had been given a newspaper of their own choice which they received every day. One resident requested to be moved to a more comfortable chair at lunchtime and was escorted to a lounge area instead of the main dining area. This showed us staff listened to people and respected their choices. The quality of communication by staff with people was generally good but varied dependant on the staff member. We observed one staff member demonstrating a very good level of communication with a person, speaking to them in a manner which was clear, calm, repeating the question as required and adapting their style for those hard of hearing when asking for meal preferences for example, through the use of written and pictorial prompts.

Relatives told us there were no restrictions on visiting times. One relative we spoke with told us they were "thankful" that they were able to visit at mealtimes and assist in supporting their relative to eat their meal.

Requires Improvement

Is the service responsive?

Our findings

People and relatives we spoke with said that they were happy with the care provided and it met people's individual needs. For example, a visitor told us staff were, "caring and I would give the home eight out of ten." Staff we spoke with generally had a good understanding of the people they were caring for and how to ensure their needs were met. Staff received a handover each morning and evening to keep up to date with resident needs; this helped ensure responsive care.

The management team was in the process of updating care records. As such, we saw some records were not an accurate reflection of people's care needs. However those which had been updated were detailed, person centred and contained information written from the viewpoint of the person. For example, one person's plan contained details about their nutritional needs and support and included information such as, 'I need staff to encourage/assist me at mealtimes and provide a fortified diet for me as I am prone to weight loss.' We saw people who were nutritionally at risk had been prescribed dietary supplements, information was contained in their care records and staff assisted people to consume these. Another person's care records contained detailed information about how to deal with behaviours that challenge, including using personalised distraction techniques. We saw some good examples of care plans being updated following changes in people's needs and conditions.

Although in most cases we found staff were responsive to people's needs, we identified some care practices within the home which were not sufficiently responsive. During the morning we identified one person was regularly crying out. When we asked a senior care worker about this, they said the person was sometimes in pain and usually settled down after their morning pain relief. However we saw they were only given their medicines at 9.45am despite being up since at least 8am. We concluded the service could have been more responsive to ensure this person's needs were met by ensuring their pain relief was given more promptly. We also observed after lunchtime a person repeatedly requested the toilet and became increasingly distressed. A staff member repeatedly asked the resident to, "wait five minutes," on over four occasions. The person waited for over 15 minutes, until another staff member was available to assist in transferring the resident from their seat at the dining table to the wheel chair. The resident returned to the lounge area and appeared to be more relaxed and settled after they had visited the toilet, however we concluded support could have been provided more rapidly.

We saw some instances where people's plans of care were not being followed. For example, one person's care record had recently been updated to state their pressure relieving cushion needed to be used at all times since their skin integrity had been assessed to be at high risk of breakdown. However, we saw when they were transferred to a wheelchair the pressure relieving cushion was not placed beneath them, nor on the dining room chair or the reclining chair they were sitting in for most of the day. We saw the reclining chair did not have integrated pressure relieving cushions. This showed us people did not always receive appropriate care and support in line with their plans of care. We spoke with the interim manager who agreed this was not acceptable

Some care records were not fully up-to-date demonstrating a lack of assessment of people's current needs.

For example, although one person was identified as being at high risk of pressure ulcers no accompanying care plan had been put in place. Another person's mobility care plan did not reflect their current needs.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

The service had recently appointed an activities co-ordinator who worked with people every afternoon during the week. We saw they worked with people in groups and on a one to one basis. They told us they were starting to accumulate materials to engage people in meaningful activities and would have their own budget to plan activities such as trips out.

People provided mixed feedback about the activities. One person told us, "I can go out in the garden when I want to and sit outside and I can do a bit of gardening." Some people told us they felt there could be more activities. One person told us, "there is not a lot that goes on," and another person said, "I do not go out much." A visitor told us, "residents do not go outside much or make much use or spend time in the garden." During our inspection, we saw people engaged in chair exercises and puzzles. We also saw the activities co-ordinator spending time with people to discuss what activities were of interest to them so they could plan accordingly. They told us about one person who enjoyed working in the garden and they were hoping to encourage more outside activities during the spring, such as gardening. Activities on offer included music, chair exercises, art, puzzles and games. We saw an entertainer came to the service regularly, carol singing with a local school had been organised for the following week and a pantomime had been put on for people the previous week. People told us they were looking forward to the Christmas party on the following week and one of the visitors had planned to bring in their bagpipes to play for people.

We observed throughout the day and found some of the staff interactions with people to be task orientated. Apart from the activity co-ordinator, staff spent minimal time in casual conversion, interaction or stimulation with residents.

None of the people we spoke with had made a complaint about their care, and two of the people we spoke with said they, "would tell the staff," if they had a problem about anything. Relatives said if there were a problem they would feel comfortable approaching staff and management about their concerns. The complaints procedure was on display to bring it to the attention of people who used the service. We saw complaints and compliments were logged, investigated and responded to. However we found some missing paperwork relating to a recent complaint. We were assured this was an isolated incident associated with the service management change and were provided with assurance this would be rectified through the new management arrangements.

Inadequate

Is the service well-led?

Our findings

A registered manager was not in place. However a new manager had recently been recruited who started work the week of our inspection. Support was being provided by a peripatetic manager, the compliance manager and area manager. We were concerned that the turnover of management within the home at the provider senior manager level was a barrier to ensuring the provision of a consistent high quality service over time.

Systems to assess, monitor and improve the service were in place, however these had not been completely effective in driving improvement. During this inspection we identified some safety concerns and examples of care plans not being followed. These shortfalls should have been identified and rectified through the operation of robust systems to assess, monitor and improve the service. At the last inspection in May 2015 the service was in breach of one regulation of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations. At this inspection, we found this regulation was still in breach at this inspection, demonstrating a lack of acting on past risk.

At the time of the inspection, the home was in a transitional phase with the previous manager leaving in November 2016. The compliance manager told us that they had identified some performance issues in the home in recent months and they hoped these would now be addressed through the new management arrangements. We reviewed the compliance manager's quarterly quality audits of the home. These included speaking with residents, observing care, looking around the home and checking documentation such as care and safety records. We found these checks had been regularly picking up issues, including some of those we identified during this inspection such as manager audits not being completed, lack of documentation around the MCA and care plans not being sufficiently robust. It was clear these issues had not been fully acted on by the home's management in a timely way, as stated by the compliance manager.

An audit schedule was in place which included regular audits in areas such as medicines, bedrails, complaints, weights, accidents and incidents, pressure sores and equipment. We identified some audits had not been completed at the required frequency. For example, there was a lack of infection control and care plan audits.

One person required documented two hourly pressure relief to reduce the risk of skin damage. However we saw turn charts were not consistently completed which meant we could not be assured that the person was receiving the required care.

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

Staff we spoke with told us they enjoyed working at the home and although morale had been poor it had picked up recently. They told us they felt comfortable in being able to raise any concerns they had regarding people or other staff with the management team. People and relatives we spoke with said the atmosphere within the home was good and they also felt able to approach senior care staff or the management team.

Staff meetings were periodically held. These were an opportunity for staff to raise any concerns and for any care quality issues to be discussed with staff.

We saw relative meetings had been held and people's feedback sought about how the home was run. People were also kept up-to-date about events within the home and their views sought through annual quality questionnaires. We saw an annual satisfaction survey had been completed by some people and relatives in August 2016 with positive comments received such as, "The staff are unfailingly helpful and kind." We did identify that more feedback could have been obtained on the meals by the cook or kitchen staff as no formal systems existed to seek people's views on the food provided.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment (1)□(2a) (2b) Risks to people's health and safety were not always assessed and mitigated

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care (1) Care was not always appropriate and did not always meet people's individual needs

The enforcement action we took:

We issued a warning notice requesting the provider be compliant with the regulation by 13 January 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance (1)□(2a) (2b) (2c) Systems and processes were not operated effectively to ensure compliance with the regulations in this part. Systems to assess, monitor and improve the service were not sufficiently robust. Systems to identify and mitigate risk were not sufficiently robust. An accurate record of each service user's care was not always maintained.

The enforcement action we took:

We issued a warning notice requesting the provider be compliant with the regulation by 3 February 2017.