All Saints Care Limited

The Gateway 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

This inspection took place on 21 June 2016 and was unannounced.

At the last inspection on 16 and 17 February and 17 March 2016 we rated the service as 'Inadequate' and in 'Special Measures'. We identified seven regulatory breaches which related to safeguarding, staffing, consent, dignity and respect, safe care and treatment including medicines, complaints and good governance. We issued warning notices for the breaches of safe care and treatment and staffing with a compliance date of 31 March 2016 and for good governance with a compliance date of 15 April 2016. We issued requirement notices for the breaches relating to complaints, consent, safeguarding and dignity and respect. Following the inspection the provider sent us an action plan which showed how the breaches would be addressed. This inspection was to check improvements had been made and to review the ratings.

The Gateway Care Home is registered to provide accommodation and personal care for up to 92 people some of who are living with dementia. There were 31 people using the service when we inspected. The home was purpose built in 2015 and provides single en-suite bedrooms over three floors with communal areas on each floor.
The home does not have a registered manager. A manager was appointed in February 2016 and is the process of applying for registration. 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.

Overall we found some improvements had been made to the care people received and areas such as care planning, activities, the cleanliness of the environment, nutrition and leadership were better than we had found at the last inspection. However, we found a number of breaches remained and we were concerned about the continued turnover of staff and the impact this has on the stability of the staff team, including the management of the service.

People and staff raised concerns about staffing levels, in particular the high turnover of staff and use of agency staff. People told us agency staff did not know them as people or how to meet their needs. They said there were sometimes not enough staff. There was no staffing tool and the manager was unable to explain how the staffing levels had been determined. We found people's dependencies and the layout of the building had not been taken into consideration.

The majority of people told us they felt safe although two people raised concerns about other people coming into their bedrooms. Safeguarding processes had improved and incidents had been investigated and reported to the Local Authority safeguarding team. Although this was not consistent as one person told us of a recent incident which had happened to them. Our discussions with the manager showed they had taken action to keep this person safe, but there were no records relating to this incident and a safeguarding referral had not been made.

We found some aspects of medicine management had improved, however inconsistencies remained which meant we could not be assured people always received their medicines safely or when they needed them.

Systems were in place to manage risk although records were not always reviewed and updated when people's needs changed. We found not all staff had received fire training and some staff we spoke with were not aware of the correct procedures to follow in the event of the fire alarms sounding which placed people at risk.

The environment was clean and well maintained. People told us they liked their rooms.

Safe recruitment procedures were not always followed as we found some staff had started work before references had been obtained. Although some staff training had taken place we found there were still gaps where staff had not received the induction or training they needed to carry out their roles. Systems were in place to ensure staff received supervision and the manager told us an appraisal system was being introduced.

People told us they enjoyed the food. We saw mealtimes had improved and were a pleasant and sociable occasion with staff providing people with the support they needed. A choice of meals, snacks and drinks were provided throughout the day.

People told us they enjoyed living at the home and described staff as kind, caring and helpful. People told us they were treated with respect and this was confirmed in our observations. People looked clean, comfortable and well groomed. We saw people enjoyed activities taking place during the inspection and people told us of other activities they had taken part in.

People were aware of how to make a complaint and we saw complaints forms were freely available alongside the complaints procedure. However, the manager was unable to provide us with any records of complaints they had received.

The service had moved from an electronic care system to paper records which staff told us worked better as they could access the information more easily. We found the care files were well organised and care plans were personalised. We saw people had access to healthcare professionals such as GPs and district nurses.

People and staff told us improvements had been made since the last inspection. We found the home was more organised and the manager was open and transparent and had a calm demeanour. However, quality assurance systems were not fully embedded or robust which is evident from the continued breaches we found at this inspection.

We found continued shortfalls in the care and service provided to people. We identified four breaches in regulations – regulation 18 (staffing), regulation 19 (recruitment), regulation 12 (safe care and treatment) and regulation 17 (good governance). The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded

The overall rating for this service is 'Inadequate' and the service remains 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.

Medicines management was not always safe and effective, which meant people did not always receive their medicines as prescribed.

People and staff raised concerns about staffing levels and the high staff turnover. Staffing levels were not always sufficient to ensure people's needs were met in a timely manner and they were kept safe. Staff recruitment processes were not robust as new staff had started work before checks were completed to ensure their suitability to work in the care service.

Risks to people's health, safety and welfare were not always properly assessed and mitigated. Overall safeguarding incidents were recognised, dealt with and reported appropriately.

Effective systems were in place to keep the premises clean, secure and well maintained.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not received all the training and support they required to fulfil their roles and meet people's needs

The service was meeting the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were met.

People's healthcare needs were assessed and staff supported people in accessing a range of health professionals.

Is the service caring?

Good

The service was caring.

People and relatives told us staff were kind and caring and this was confirmed through our observations.

People's privacy and dignity was respected and maintained by staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records had improved and contained personalised information although some sections needed reviewing and updating.

An activities programme was in place and trips out were being arranged. We saw people enjoying activities on the day of the inspection.

A system was in place to record, investigate and respond to complaints, however, the manager could not locate records of complaints received.

Is the service well-led?

Inadequate

The service was not well-led.

Systems had been introduced to assess, monitor and improve the quality of the service, however these needed to be fully embedded. Although, some improvements had been made, regulatory breaches remained which placed people at risk of receiving unsafe care and treatment.

Leadership and management of the home had improved, however the stability and consolidation of the staff team is a critical factor in ensuring improvements made are sustained and developed further.

The Gateway 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 21 June 2016 and was unannounced. The inspection was carried out by three inspectors.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioning and safeguarding teams.

Usually we ask 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. We did not ask the provider to complete a PIR before this inspection.

We spoke with 12 people who were living at the home, five visitors, four night care workers, three senior care workers, four care workers, two agency care workers, three housekeepers, the chef, the activities co-ordinator and the manager.

We looked at five people's care records in depth and four other people's for specific information, four staff files, medicine records and the training matrix as well as records relating to the management of the service. We looked round the building and saw people's bedrooms and communal areas.

Inadequate

Is the service safe?

Our findings

At the last inspection we found there were not always sufficient staff deployed to meet people's needs and we had the same concerns at this inspection

One person told us, "If I press the buzzer they come but they can be a bit slow if they are short staffed. Sometimes staff ring up late and then they can't find any cover so they are short staffed." A second person said, "The response time to the buzzer varies, can be quick or slow. I think they are short of staff." Another person said, "There's not enough staff at night, they're rushed off their feet." A further person said, "They are always short of staff here." A visitor told us, "The staffing levels vary and I don't think there are always enough staff."

People expressed concerns at the turnover of staff and the impact this had on the care they received. One person said, "There's been a massive staff turnover. Staff do their best but you don't get to know them as they don't stay. A lot of the agency staff don't know what care I need."

Staff also commented on staff turnover, which they said was unsettling for both staff and people using the service. Night care workers said it was better when all permanent staff were on duty rather than working with agency staff, who were not always familiar with people or their routines. The day staff said they felt an addition member of staff on duty on the ground floor would be beneficial. The consensus was some days they felt 'stretched' and did not have the time they would like to spend with people. However, all agreed the current staff team were very good and worked well together.

There were 31 people using the service when we inspected. The manager told us the usual staffing levels were two seniors and six care workers throughout the day and one senior and three care workers during the night. However, further discussions with the manager showed one of the care workers during the day was a staff member from another organisation who provided one-to-one support to one individual. This meant the actual staffing levels during the day were two senior care staff and five care workers for 30 people accommodated over three floors.

The rotas we looked at for the four weeks leading up to the inspection showed overall these staffing levels were maintained. However, there had been one day when only seven care staff were working, which included the one-to-one support and although there had been four staff on at night none of these was a senior staff member and therefore the senior from days had stayed to administer medicines. Agency staff were used to cover any shortfalls in staffing and rotas showed this was mainly at night.

We asked the manager how they determined staffing levels and if there was a tool they used. They told us they had looked at different tools and methods for calculating safe staffing levels. They acknowledged there was not a system in place currently which determined people's dependencies or considered the layout of the building.

During the inspection we found staff were visible and available to provide assistance to people when

required. The manager told us they were continuing to recruit new staff and some appointments were imminent pending completed recruitment checks. However, we were aware of staff who were leaving and those who had left since the last inspection. Information provided by the manager showed 15 of the 37 staff employed at the home had started in post since 17 February 2016. We remained concerned about the turnover of staff and stability of the staff team. In particular the impact this will have on the long term sustainability of safe care and treatment. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations

The home was using assistive technology to help reduce the risk of falls. For example, we saw one person who had fallen had a sensor mat by their bed and wore a falls detector during the day. Both devices triggered an alarm if the person started to get out of the bed or chair so staff were alerted and could offer assistance. However, we found risk management plans were not always reviewed and updated following falls to show how the provider was mitigating the risk of these incidents occurring again. For example, accident reports showed one person had two unwitnessed falls in their bedroom. The risk assessment had been updated and the risk of falling had increased to high and indicated a risk reduction plan was required. The previous assessment had required their bed was at the lowest level and there was a crash mat at the side of the bed. When we looked in their bedroom we saw these were still in place but no additional measures had been put in place to further mitigate the risk.

Risk assessments were completed to identify people who were nutritionally at risk and staff were able to tell us which people were having their food and fluid intake monitored. However, we found the completion of these records was inconsistent and no assessment was being made about the adequacy of people's intake. There was also no information for staff about what each individual's optimum fluid intake should be each day. For example, one person's fluid intake over a 24 hour period had been recorded as 700mls when their optimum intake of fluids should have been 1440mls (based on 30mls per kg of body weight). We discussed this with the manager as the record sheets had the provision for staff to make an assessment about people's diet and fluid intake. They told us these forms were new and staff needed further training to ensure they were being fully completed.

Some of the care workers we spoke with had not taken part in a fire drill and were unclear about what they should do in the event of a fire. Staff also told us they had no means of communicating with each other when they were working in different areas of the home other than activating the call bell system. The provider advised staff had access to three cordless phones on each floor, however our discussions showed not all staff were aware of this. We looked at the fire procedure and saw this provided staff with conflicting information about what they should do if the fire alarms sounded. We looked at the fire risk assessment dated 7 June 2016, which identified the risk rating as 'medium' because of the lack of clarity relating to evacuation procedures, personal emergency evacuation plans (PEEPS) documentation, lack of staff fire safety training from a competent person and a final exit fire door which opened onto a small gated area which was padlocked. The timescale given for these issues to be addressed was one month. The manager was aware of this and gave assurance all would be completed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations

At the last inspection we found medicines were not being managed safely and properly. During this inspection we found that although improvements had been made more needed to be done to ensure the consistent safe and proper management of medicines.

Medicines were stored securely. The temperature of the treatment rooms and medicines fridges were checked every day and were within the recommended safe limits.

Some medicines were prescribed with specific instructions about how they should be given in relation to food. We saw there were arrangements in place to make sure these instructions were followed.

Some medicines are classified as controlled drugs because there are particular rules about how they are stored and administered. We checked the storage, the records and a random selection of stock and found they were correct.

We looked at the medication administration records (MARs). Most people had printed MARs which had been supplied by the pharmacist. However, some people also had hand written MARs. A senior staff member told us it was the provider's policy that when MARs were hand written they should be checked and signed by two staff to reduce the risk of transcribing errors. We found this was not always done.

Medicines were supplied on a four weekly cycle and when they were delivered to the home the provider's policy stated they should be checked and signed for by two senior staff. Those staff were also responsible for following up any discrepancies to make sure people had all their prescribed medicines at the start of the new cycle. If the medicines were checked in out of hours the information was to be passed on to be followed up when the pharmacy was open. We found this was not always done. For example, the new cycle started on 20 June 2016 and while observing medicines being administered on 21 June 2016 we found two people had not received a new supply of Complan. The Complan was not on the MAR commencing 20 June 2016 although it was on the MAR for the previous cycle and on the list of medication which was in the same file as the MARs. A senior care worker confirmed this had not been passed on by the staff who had checked in the medication and had not been identified until it was brought to their attention by the inspector. This was dealt with in the course of the inspection.

Another person's MAR showed the home had not received a new supply of two prescribed medicines. A senior care worker said the medicines had been discontinued. They were marked as discontinued on the MAR for the previous cycle but there was no date or signature on this entry. We looked in the person's care records and could not find any record of when the medicines had been stopped. This was discussed with the manager. They said they had identified there was an issue with the checking in process and were in discussions with the pharmacy to have the new supplies delivered sooner to allow staff more time to check and follow up discrepancies. They said the newly appointed team leader would be the designated lead for medicines and would work with all the senior care workers in turn to make sure they were competent and confident in the procedures for checking in new medicines.

We found the process for obtaining medicines prescribed outside of the four weekly cycle was not always effective. For example, one person had been prescribed an antibiotic and there was a delay of four days before they received the first dose. Staff said this had been due to a mix up between the doctor's surgery and the pharmacy. However, there was no evidence staff at the home had followed this up.

We found the processes for managing topical medicines such as creams and lotions were not always effective. Body maps had been put in place to show staff where and when to apply the creams/lotions but we found they were not consistently signing the charts and therefore we could not be assured they were being used as prescribed.

We found one person missed their morning medicines because they had gone out for the day. Staff were aware the person was going out but had not made any arrangements for them to have their medicines early.

Another person was prescribed two different medicines which contained Paracetamol and the instructions

clearly stated they should not be given at the same time. The MAR dated 20 June 2016 showed both medicines had been given at the same time. In the same person's records we found conflicting information about medication allergies with one record stating the person was allergic to Paracetomol which was of concern as the person was prescribed medicines containing Paracetomol. This was followed up with the person's GP during the inspection but had not been identified until the inspector brought it to the attention of senior staff.

Some people were administering some or all of their own medicines and there were risk assessments in place. However, these were not always up to date. For example, one person was self-administering some of their medicines but the records stated this had been stopped because of an increase in the assessed risk. We discussed this with the manager who told us the risk assessment had been reviewed again and the decision reversed but the risk assessment had not been updated to reflect this.

Some people's MARs did not have a photograph and there were no photographs or names on people's bedroom doors. This could make it difficult for staff who were not familiar with people, for whatever reason, to identify them when administering medicines.

We checked some stock balances and found most were correct. However, in one case there was a discrepancy of eight tablets which we were not able to find an explanation for. We also found eye drops for one person which had not been dated when they were opened. This was important because the instructions stated they should be discarded within four weeks of opening.

We found the manager had introduced a daily audit of medicines. This had identified some discrepancies and there was evidence the manager had taken action in response to these shortfalls. However, as detailed above we found some discrepancies which had not been picked up by the daily audit.

The manager also told us they were doing a more detailed medicines audit twice a month and assured us this would continue until they were satisfied medicines were being managed safely.

We concluded while some improvements had been made since the last inspection which reduced the risk of people not receiving their medicines as prescribed the provider remained in breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found improvements had been made in relation to safeguarding. Staff told us they had received training in safeguarding adults and were clear about how to recognise and report any suspicions of abuse. They were aware of the whistleblowing policy and knew the processes for taking serious concerns to external agencies if they felt they were not being dealt with effectively. Safeguarding records we reviewed showed appropriate referrals had been made to the local authority where concerns had been identified. There was also evidence to show the incidents had been investigated and action had been taken to ensure people were protected. Most of the incidents had been notified to the Care Quality Commission, although we had not been notified about four of them. Following the inspection the manager notified us of these incidents retrospectively.

The majority of people told us they felt safe in the home. However, two people told us on occasions other people who used the service came into their bedrooms which they did not like. One of these people described an incident which had occurred recently when a person had come into their room and touched their head which they said had scared them. They told us the manager had dealt with this incident and when we spoke with the manager we were satisfied appropriate action had been taken. However, we could find no record of the incident, the action taken or evidence to show a safeguarding referral had been made.

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

We looked at the recruitment process for three staff. Records showed prospective staff completed an application form and detailed their employment history and qualifications. Checks on staff character were undertaken to ensure they were suitable for the role. This included obtaining a Disclosure and Barring Service (DBS) check, obtaining references and ensuring an interview was held. However, we found references had not always been received before the staff member commenced in post. For example, one staff member's records showed they started in post in March 2016. One reference was dated four days after they started and the other was received in April 2016. Another staff member had started in February 2016, one reference was dated four days after they started in post and the other had been received in April 2016. The other staff member had started in June 2016 and one reference had been obtained before their start date, but the other reference was undated and the manager was unable to confirm when this had been received. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations

We found the building was clean and well maintained. 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. As the service only opened in 2015 they had not been inspected by the food standards agency. The chef explained they had made an application so this inspection could take place. On the day of our visit the infection prevention team were completing an audit of the premises and practices in the home. Following the inspection they informed us the home had scored 92% in the audit.

Requires Improvement

Is the service effective?

Our findings

Care workers we spoke with told us training was on offer, but some said they were not up to date or had not completed all of the relevant training courses. This was reflected in the training matrix we reviewed which showed some training had taken place since the last inspection which included infection control, medicines, first aid, food hygiene, care planning and safeguarding. However, there still remained significant gaps where staff had not received training or the necessary updates. For example, the matrix showed 15 of the 27 care staff listed, including managers and seniors, had not received any moving and handling training. The manager acknowledged the shortfalls and told us training was ongoing. They said they were arranging specialist training in topics such as Parkinson's Disease, diabetes and dementia care. One visitor told us they felt care staff needed more dementia care training so they could develop their understanding of how they could best support people in their care.

The manager told us new staff completed induction training and were enrolled on the Care Certificate. The Care Certificate is a set of standards for social care and health workers. It was launched in March 2015 to equip health and social care support workers with the knowledge and skills they need to provide safe, compassionate care. We looked at four staff files and saw one of the staff had completed the Care Certificate. There was evidence of induction for another staff member but no evidence for the other two staff. We asked the manager about this and they were unable to provide us with evidence of an induction for either of these staff. We spoke with one of these staff who told us they had not received any induction training, although they confirmed they had received safeguarding, moving and handling and dementia training since starting in post. They said when they had started they had shadowed staff for one night and were then included in the staff numbers. They confirmed they had received no fire training.

We saw evidence of supervision in three of the four staff files we reviewed. The fourth staff member had only commenced in post in recent weeks. The manager told us they were setting up an annual planner to ensure staff received supervision monthly. The manager confirmed no appraisals had been completed as the home had only been open nine months, although they were looking to put these in place. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The manager told us they had made DoLS applications for some people. There were no DoLS authorisations currently in place although the manager told us they had received an email during the inspection confirming

a DoLS application had been approved for one person but had not been given any details. We contacted the Local Authority DoLS team following the inspection who confirmed 19 applications had been made and of those two had been withdrawn, one had been declined and one had been approved on the day of inspection.

One person was having their medicines covertly. The records stated the person should be offered their tablets and if they spat them out they could be 'given covertly in yoghurt'. A senior care worker told us the decision to do this had been made in the person's best interests. However, there was no written evidence to show when the decision had been made and by whom. There was no information about giving covert medicines in the medication care plan which stated the person was compliant and took their medicines well. There was no assessment of the person's capacity and no evidence in the care records that their family had been involved in planning their care and treatment.

We observed staff asking people for consent and explaining what they were going to do. For example, when administered medicines we saw the senior care worker respected one person's right to refuse some of their medication. In another example, one person said they were not ready to take their medicines because they had just woken up, staff went back about half an hour later by which time the person was happy to take their medicine.

Although we saw people's consent was gained in practice this was not reflected in the care records. There was no evidence in people's care plans to show they had consented to care and treatment. There was a consent form for a photograph; none of these had been completed. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

One person told us, "The food is not bad, most meals you get a choice. There are lots of things I don't like so they will make me an omelette." A second person said, "The food is alright." Care workers told us there were always plenty of snacks available for people such as biscuits, crisps and cakes. One care worker said, "Sometimes people complain about small portions." Another said, "I'd eat the food."

We saw tables were set with tablecloths, cutlery, crockery and napkins. As people got up they were offered hot and cold drinks, cereals and toast and jam by the night staff. When the chef arrived porridge and a full English breakfast was available. One person told us, "I like to get up early and I have cereal and a cuppa. Then when the chef comes on I'll have a bacon butty. The chef's very good, we get a choice and if it's something I don't like he'll get me something else."

Mid-morning people were asked what they wanted for lunch, there were two hot options and if people did not want either of these omelettes, sandwiches, fish fingers, curry or jacket potatoes. Lunch was served from hot trolleys and was nicely presented. Care staff served one table at a time, so no one was left watching other people eating with no food themselves. We heard people say 'nice' and people told us the corned beef hash was very good. Although we saw some people cleared their plates no one was offered second helpings. People were offered both hot and cold drinks. We saw people were offered hot and cold drinks with their meal and throughout the day together with a variety of snacks.

We spoke with the chef who showed us the three week cycle of menus. They explained they would change the menus to suit people's tastes, so they were getting meals they liked. The chef had information about people's specific dietary needs and was building up individual profiles of people's likes and dislikes. They explained how they fortified foods for people who were at risk of losing weight. This showed us they had a good understanding of people's dietary needs. We looked at the weight records for some people who had been assessed as being nutritionally at risk and saw they were putting on weight. We concluded people's

dietary needs were being met.

We asked people using the service and visitors if their healthcare needs were being met. One person told us, "They will get the doctor if you need them. A couple of months ago I was short of breath and they called for an ambulance straight away." A visitor told us, "The optician has been and they are trying to get a dentist." Care records showed people had been seen by a range of health care professionals including GPs, community matrons, district nurses, specialist nurses, dieticians, opticians and podiatrists. This meant people's health care needs were being met

Good

Is the service caring?

Our findings

We asked people what they thought about living at the home and their views on the staff. One person told us, "I get on well with the staff. It's better here than I thought it would be." A second person said, "I like it here I think it's very good. It's nice and quiet and there is no trouble." A third person added, "Staff are helpful and lovely. They are respectful of privacy and dignity and have really brought me out of my shell." A fourth person said, "I get on very well with the staff."

Visitors told us, "Mum is very happy and feels very much at home. Staff are very kind and gentle." and "The staff are friendly, helpful, caring and approachable."

An agency member of care staff told us, "Staff are very supportive and nothing is too much trouble. They are kind and patient and support relatives as well."

Two visitors told us, "We are always made to feel welcome and offered a drink, cake or biscuits."

The activities co-ordinator told us they had been finding out about people's life histories and personal preferences and this information was in the care files. We asked care workers if they had time to read the care plans and they all told us they did and said the information was helpful and gave them a better understanding of each individual.

We saw people looked cared for, were wearing clean clothing and were well groomed. People we spoke with told us they could have a bath or shower when they wanted. One person said to us, "That has improved since you last came."

People told us staff treated them with respect and we observed staff were courteous and kind when interacting with people. We saw staff knocked on bedroom doors before entering people's rooms and any personal care was carried out in private. For example, we saw staff helped a person to their bedroom when the district nurse visited so they could examine their skin for pressure damage. One person told us they preferred to have their bedroom door locked at night and not to be disturbed by staff checking on them and staff respected this.

People who used the service told us they were very happy with their accommodation. One person told us, "My bed is very comfy and I don't want to get out of it." A second person said, "My bedroom is comfortable and kept clean. It can be a bit cold because the windows are open during the day."

We found a pleasant atmosphere within the home with staff and people getting on well. We saw people had free access to two garden areas, one at the front and one at the rear of the building. Both provided nice sitting areas for people and visitors. One person told us how much they enjoyed sitting outside. There was a café area in the front entrance, which some visitors told us they liked to use.

We saw there was some good signage around the building to help people find various rooms; however, most

bedroom doors were only identifiable by a number. We saw there was provision to put photographs or other meaningful pictures on the doors, to help people find their bedrooms, but most of these had not been utilised.

We saw useful information for people and relatives was freely available in the home. This included the last inspection report, the home's brochure, fact sheets produced by the Alzheimers Society and photographs of the staff team. There was also a Freephone for ordering taxis.

Requires Improvement

Is the service responsive?

Our findings

Following the last inspection the provider changed the care records from an electronic system to paper records and we saw this had brought about improvements. We saw each person had their own care file which was accessible to staff. The care files contained personalised information about people's care needs. Some of the care plans were detailed and showed what the person could do for themselves as well as the support they required from staff. For example, one person's care plan showed they preferred a shower and needed help from staff with shaving. Another person's care plan showed their preference for female staff and described how they liked to apply their own creams. However, we found other sections were not as well completed and did not always reflect information we found elsewhere in the care file. For example, one person's records showed they had lost weight and had been seen by the dietician on 23 May 2016. The dietician had recommended the person was to be offered full fat milk and snacks, yet there was no reference to this or the person's weight loss in the care plan which had not been reviewed or updated since April 2016. Another person we spoke with told us they had lost their dentures, yet when we looked in this person's care file there was no record of this. We spoke with the manager who confirmed the dentures were missing and was able to show us that a dental referral had been made. However, this was not reflected in the care plan.

There was no evidence to show people and/or their relatives were involved in the care planning process. The manager told us people were consulted but acknowledged this was not reflected in the care records. We asked two people if they had been involved in their care plans; neither had heard or knew about their care plan.

We saw Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms were kept in a separate file in the office. This meant there was no way for staff to know who had a DNACPR in place other than going to the office and checking the file. In the event of an emergency this could cause unnecessary delay and could potentially mean that a person would receive CPR against their wishes. This was discussed with the manager who told us they were in the process of reviewing all the DNACPR forms with the Community Matron. We looked at five people's DNACPR forms, three had been completed correctly. However, in the case of two people who were assessed as lacking capacity there was nothing on the forms to indicate the decision had been discussed with the person's family or representatives.

When we arrived at 7am we found three people were up and dressed and sat in the lounge. We spoke with all three of them. They told us they had had their breakfast and we saw they had drinks. Two of the people told us they liked to get up early. The third person didn't and said, "They do get me up early. I was up at 6.30am. I'm not keen on it. I'd prefer to be up about 9 o'clock." We checked this person's care plans and there was nothing recorded about their preferred times for getting up or going to bed.

We met with another person who had moved rooms from one floor to another. They told us they were not happy in the new room and wanted to move back to the floor they were on previously. The daily records showed the person had raised this with staff two days before our inspection. We discussed this with the manager who told us they would speak with the person and arrange for them to be moved. However, we were concerned that this had not already been done when the person first raised concerns and there was

nothing in the person's care records to show when or why they had changed rooms or who had been involved in the decision. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

People told us there were activities taking place, although one person told us these were limited and felt there was very little to do. Another person said, "Here they do throwing a ball. I go out to the Church day centre." A second person said, "I did some gardening the other week. We put flowers into the planters outside." A third person said, "We have music and ball games." One of the care workers told us, "People sit outside when it is a nice day. Gardening, reading, and board games are on offer and we get some entertainers coming in."

We saw people enjoying an exercise session, singing and dancing and spending time talking to the activities co-ordinator.

We spoke with the activities co-ordinator who explained they worked 20 hours per week over three days. They told us another activities co-ordinator had been recruited to work the same amount of hours, but had not started work yet. We saw there was an activities timetable on display and activities on offer included ball games, exercises, gardening, music, singing and dancing, bingo and boules. The activities co-ordinator also explained they had started to arrange trips out to the new shopping centre in Bradford, a garden centre and were planning trips to Marks and Spencers and the St Ives Estate. They told us outside entertainers came in to the home and they had also built up links with two local schools who had committed to bringing their choirs into the home. People's care records showed they had participated in activities during May and June, which included a singer, chair exercises and a party to celebrate the Queen's 90th birthday.

People we spoke with knew how to make a complaint and said they would speak to staff if they had any problems. One person told us, "If I was unhappy I would tell [name of manager] or [name of owner]." Another person told us, "I'd speak to [name of manager]. They're ace and very approachable." However, one person we spoke with was not confident that issues they raised would be dealt with. They said, "If you speak to management it's in one ear and out the other."

The manager told us new complaint and compliment forms had been developed. We saw these were freely available in the main reception area with the home's complaints procedure. There was a suggestion box where people could submit the forms. However, when we asked to see records of complaints received since the last inspection, the manager could not locate this information.

Inadequate

Is the service well-led?

Our findings

It was evident from our observations and feedback from people, relatives and staff that improvements had been made since the last inspection. However, we found a number of breaches remained which demonstrated shortfalls in the quality of care people received. Quality assurance systems were in their infancy and were not yet fully embedded to ensure continuous improvement of the service. These factors combined with the fragility of the management team and continued high turnover of staff led us to conclude the service was not well-led.

The home did not have a registered manager. The manager who started in post in February 2016 told us they had begun the process of applying for registration with the Care Quality Commission.

Overall we found the home was better organised and the manager had put systems in place to improve communication across the staff team. We asked staff about the management of the home. One staff member said, "[Name of manager] has an open door policy and they are 'out and about' around the home."

We asked staff what improvements had been made since our last visit in February and March 2016. One staff member said, "The paperwork has improved and the training." Another staff member told us, "It's more organised now, for example, disposable gloves and aprons are in bedrooms and bathrooms so we don't have to go looking for them." A third staff member said, "The care has got better and it's more organised."

Two visitors told us they had experience of other care services and said, "This is the best home we have been to."

We found the provider and manager were willing and committed to making improvements to the service, although the turnover of staff had a significant impact on the progress made. The management team was depleted as the deputy manager had left recently and although a replacement had been appointed they had not yet started in post. The manager told us a new management structure was being put into place to support them in their role but this had not yet happened. They confirmed there were still staff vacancies in both caring and ancillary roles and although some appointments were pending others had yet to be filled. We considered the stability and consolidation of the staff team was a critical factor in ensuring improvements made were sustained and developed further.

As stated in other sections of this report we found records relating to people's care and treatment were not always up to date, accurate and complete. For example, there were no records of an incident which had occurred with one person or evidence to show the action taken by the manager.

We saw evidence which showed some quality assurance systems had been put in place but these had not been fully embedded and it was not always clear how the information from audits was being used to secure improvements in the quality of care provided. For example, although medicines audits were being carried out on a regular basis many issues we identified had not been picked up or addressed.

We saw the manager carried out daily 'walk round' audits which they told us involved discussions with people who used the service and staff, yet this was not reflected in the forms we saw which focussed on the environmental checks.

We saw copies of audits completed by an external consultant in February and May 2016 which assessed the service on the Key Lines of Enquiry (KLOEs) used by the Care Quality Commission. These identified where improvements had been made and suggested areas for further development, although we found no action plan to show how these matters were being taken forward.

We saw accidents and incidents were being listed on a monthly basis. The form had a section for senior managers to identify any trends or areas for improvement; however, this section had not been completed and signed off. This meant we were unable to find any evidence to show this information had been analysed and used to look for patterns which could identify avoidable falls or injuries in the future. The manager told us they would be putting this in place.

We asked if the manager if there were any systems in place to audit the care records. They said although the care records were reviewed on an individual basis there was no overall audit to monitor the quality of the care records.

We saw health and safety audits were being completed on a monthly basis and the last one undertaken in June 2016 showed full compliance in all areas.

We found required notifications such as allegations of abuse and deprivation of liberty safeguards information had not been reported to the Commission as required. For example, we had not been notified of four safeguarding alerts or the outcome of three DoLS applications.

We saw satisfaction questionnaires had been given to people in March/April 2016 and nine had been returned. These showed a high level of satisfaction, although some people had made comments about how they thought the service could be improved. Three people commented more staff were needed, one person said call bells needed to be answered more quickly, one person wanted cooking and baking as an activity and others wanted singers coming in and bingo. No analysis of the surveys had been completed and people had not been given any feedback about what had been done in response to their suggestions.

We saw the minutes of residents and relatives meetings which had taken place in May and June 2016. At the first meeting people had made a number of suggestions about improvements they would like to see and there was a lot of discussion. At the second meeting we could see some of these had been responded to, for example, people said the activities had improved. However, there was no discussion recorded about the action which had been taken following the first meeting so people were kept updated on the progress of improvements.

We saw meetings had been held with staff in April and May 2016. We saw discussions centred around the improvements that needed to be made following our inspection in February and March 2016 and subsequent visits from the Local Authority.

We saw a notice about CCTV was displayed outside the office and asked the provider about this. The provider told us CCTV cameras were present outside the home, in the entrance to the home and in the office. We asked if this included audio as well as visual recordings. The provider told us there was a recording device on the CCTV camera in the office only which could be switched on and off. The provider told us there were notices informing people of this, although we did not see these and the recording device

had not been brought to our attention during the inspection. The provider informed us the device had been switched off and said they always informed people when the recording was switched on. Although there was a notice advising CCTV cameras were in use this did not inform people that there was also a recording device in place in the office or provide information about when, how and in what circumstances the recording device would be used. Issues around human rights including consent and privacy also need to be considered in terms of all those who may have conversations in the office including people who use the service, staff, relatives and visiting professionals.

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