Wellburn Care Homes Limited

St Catherine's Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 16 February 2016. The service was last inspected in June 2014, when the service was compliant with the regulations assessed at that time.

St Catherine's Care Home is registered to provide personal and nursing care for up to 55 people, including older people, people living with dementia and people living with physical disability.

The service did not have a registered manager at the time of the inspection. There was a manager working at the service who had been confirmed in role during January 2016 and have since registered with us. 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.

At the time of our inspection the service was providing care to 43 people. The home was divided into two distinct units: The Mews provided care for people living with dementia, while Harewood provided nursing care. At the time of our visit 21 people had been assessed as needing care because they were living with dementia and were cared for in The Mews. 22 people had been assessed as needing nursing care and were cared for in Harewood.

We found that there had been occasions when people had not received safe care and treatment and this had impacted on their wellbeing. Several of these matters are still under investigation.

During 2015 incidents had not always been reported to the local safeguarding authority appropriately. Recent improvements in reporting had been made and staff now understood safeguarding processes and their reporting responsibilities.

There had not always been enough suitably competent, skilled and experienced staff on duty to meet people's needs. Recruitment of new staff was in progress, with existing and agency staff being used to cover shifts wherever possible. Recruitment checks were being completed before new staff started work, to ensure they were suitable.

Medicines were being stored and administered safely. However, there was no system for the use of homely remedies so that these medicines were available to people who used the service when needed.

We found that staff training and supervision systems had not been effective at ensuring staff had the competence and skills they needed to meet people's needs. Improvements were being made, with new systems being put in place to support staff.

People's nutritional needs were being assessed and monitored. Some people at the service had lost weight,

but information about the actions taken to ensure people's nutritional wellbeing, including involvement of other professionals, was available and being monitored by the manager on a monthly basis. We saw that mealtimes on The Mews were noisy, cramped and chaotic. The current arrangements did not support people living with dementia to have a pleasant meal time experience.

Staff had a basic understanding of the Mental Capacity Act 2005 (MCA) and where appropriate had sought authorisation to deprive people of their liberty. However, individual care plans did not contain a lot of information about capacity, consent or decision making in relation to each person or the support they required.

The majority of staff treated people kindly and were caring in their approach, although feedback from relatives suggested some staff were less proactive and interactive in the way they supported people than others. This suggested a lack of consistency, depending of the competency and skill of individual staff members. We observed people being treated with respect and staff we spoke with understood the importance of maintaining people's dignity while providing care.

Assessments, risk assessments and care plans were in place, but it was difficult to gain a complete understanding of people's care needs and it was difficult to follow through people's care and understand what had happened to them. Some individual needs had not been identified or planned for and we found examples where identified care needs had not been followed through.

A complaints process was in place but people had not always been satisfied with the response they had received when raising issues or concerns. Records of past complaints and the actions taken were not available, although we could see that recently improvements had been made to the way complaints were recorded and handled.

Individual staff were responsive and tried hard to offer choices and meet people's needs and requests. The activities coordinator was well thought of and people enjoyed a variety of activities and events.

CQC had not received all of the required statutory notifications during 2015 and we are pursuing this separately with the provider. The new manager was aware of notification requirements and appropriate notifications had been made in 2016.

Governance systems had not been effective at assessing, monitoring and improving the quality and safety of the service or mitigating risk. This was demonstrated by our inspection findings, particularly in relation to people's care. Records relating to people's care were not maintained to a suitable standard. We found records that were incomplete, not accurate and in some cases difficult to understand or illegible.

The culture at the service had not always been open and transparent. Staff described a past culture of 'sugar coating' or 'hiding' things and during 2015 incidents had not always been appropriately reported to external organisations. The new manager was open and honest about the service and the improvements that were needed. People using the service, relatives and staff were complimentary about the new manager, their approach and the changes and improvements they were making.

There had been a period of management change and instability. There was a new manager in post, who has now registered with us. They had a challenging role and needed additional senior management support to help them achieve the required improvements.

We identified five breaches of regulation. You can see what action we told the provider to take at the back of

the full version of the report. Where more serious breaches have been identified we have taken enforcement action.

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.

People had not always received safe care and treatment and incidents had not always been reported to the local safeguarding authority appropriately. Recent improvements had been made and staff now understood safeguarding processes and their reporting responsibilities.

There had been insufficient staff on duty to meet people's needs. Recruitment was now underway and recruitment checks were completed before new staff started work.

Medicines were being stored and administered safely. There was no system for the use of homely remedies to ensure these were available when needed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff training and supervision systems had failed to ensure staff had the competence and skills they needed to meet people's needs. The manager was addressing this with new training and supervision initiatives.

People's nutritional needs were being assessed and monitored. The dining room facilities on The Mews did not support people living with dementia to experience pleasant mealtimes.

Staff had a basic understanding of the Mental Capacity Act (MCA) and where appropriate had sought authorisation to deprive people of their liberty.

Is the service caring?

Good

The service was caring

The majority of staff treated people kindly and were caring in their approach.

People were treated with respect and staff understood the

importance of maintaining people's dignity while providing care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Assessments and care plans were in place, but it was difficult to gain a complete understanding of people's care needs. Some needs had not been identified or planned for and we found example's where identified care needs had not been followed through.

A complaints process was in place, but people had not always been satisfied with the response they had received when raising issues or concerns.

Individual staff were responsive and tried hard to offer choices and meet people's needs and requests. The activities coordinator was well thought of and people enjoyed a variety of activities and events.

Is the service well-led?

Requires Improvement

The service had not been well led.

Statutory notifications had not been submitted during August and September 2015.

Governance systems had not been effective at assessing, monitoring and improving the quality and safety of the service.

Records relating to people's care were not accurately maintained or complete.

The culture at the service had not always been open and transparent, but the new manager was making improvements in this regard.

There had been a period of management change and instability. There was a new manager in post and they have now registered with us.

St Catherine's 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 16 February 2016 and was unannounced. The inspection was carried out by one inspector, a bank inspector and a specialist professional advisor (SPA). The SPA was a registered nurse with management and general nursing experience.

Before our inspection we reviewed all the information we held about the service. We reviewed all of the notifications and safeguarding alerts we had received. A statutory notification is information about important events which the service is required to send to the Commission by law. We also looked at the provider information return (PIR) which the provider had completed and returned to us. A PIR provides us with information about the service, including what they do well and what they want to improve.

We spoke with the local authority contracts officers and commissioning officers from City of York Council and North Yorkshire County Council. We also spoke with a representative from the local Clinical Commissioning Group (CCG). The CCG commissions nursing services.

We contacted Healthwatch, which is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. They did not have any information to provide in relation to St Catherine's Care Home.

During our visit we spoke with seven people who used the service and six of their relatives. We also spent time observing the care and support provided to people. 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 spoke with the manager, deputy manager and clinical lead. We also spoke with nine staff including nurses, care workers, the chef, laundry and domestic staff.

We looked at documents and records that related to people's care, and the management of the service such as training records, quality assurance records, policies and procedures. We looked at four care plan records and six staff files.

Inadequate

Is the service safe?

Our findings

We identified that during late 2015 and early 2016 staff had not always provided care and treatment in a safe way. There were examples where this had affected or had the potential to affect people's wellbeing. For example, there had been a delay between a person experiencing a fall and staff identifying an injury and obtaining appropriate medical intervention. Another person had been assessed as at risk of pressure damage and needing three hourly positional changes to manage this risk. The person's positional changes record did not evidence any positional changes being completed regularly, including the day before a pressure ulcer was identified by staff. The ulcer was treated promptly and healed quickly, but may have been preventable if the person had received more regular positional changes. Another person had been assessed as being at 'very high risk' of developing pressure ulcers. Staff failed to record any warning signs or take any additional preventative actions prior to the discovery of a pressure ulcer, despite care staff noticing changes to the person's skin condition and reporting this to nursing staff at the time. We also found two other examples of injuries people had sustained where the cause was either unknown or unclear.

We received feedback from relatives that staff did not always supervise communal areas when needed. This was raised as being particularly important on the Mews unit where people were living with dementia, and might not recognise risk or could become distressed or aggressive. We also saw incident records that suggested the communal areas had not always been effectively supervised by staff. For example, a fall from a wheel chair during a mealtime in September 2015 and a violent incident between people using the service in December 2015.

The local authority was aware of the issues and was undertaking individual safeguarding investigations into cases where concerns around individual care delivery had been identified.

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

We spoke with the new manager and newly appointed clinical lead about these incidents and the actions being taken to ensure people received safe care and treatment. The clinical lead had been appointed to help implement changes to nursing practice, in recognition of the improvements that were needed. Where appropriate, staff who had not provided people with safe care were no longer at work and subject to disciplinary processes and investigations. Checks were being completed on care documentation and the importance of recording had been highlighted to staff during meetings. New training was being implemented, with plans to involve relevant professionals such as the community matron and tissue viability nurse to help develop staff skills and ensure people's needed were met.

Historically incidents between people who used the service had not been recognised as abuse and safeguarding alerts had not been made in accordance with local safeguarding procedures. For example, we found records of five incidents between people who used the service during August and September 2015. These had not been referred to the local authority as safeguarding alerts. In addition, we identified two further delays in recognising and making safeguarding alerts which occurred during December 2015. This

meant that people had not been adequately protected from abuse, because staff had not ensured that safeguarding events were reported to the local safeguarding authority.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safeguarding service users from abuse and improper treatment.

We spoke with the new manager about safeguarding procedures during our visit. They were able to describe when and how safeguarding alerts should be made. The manager acknowledged that there had been shortfalls in past reporting and was able to show us what was being done to make improvements. For example, they had gone through safeguarding procedures in recent staff meetings, to make sure staff understood the importance of reporting any concerns. Additional safeguarding training was also planned. Staff were aware of different types of abuse and safeguarding procedures and the importance of reporting allegations or suspicions of abuse. There was evidence of the service making six safeguarding alerts so far during 2016, which showed that improvements were being made to staff understanding and the reporting of safeguarding incidents.

We looked at staffing levels and how the registered provider ensured there were enough staff on duty. The monthly management reports for December 2015 and January 2016 showed that over 300 hours less than the care hours required had actually been provided. Staff told us that there were not always enough staff, but that most staff were happy to undertake extra shifts, which they felt was better than using agency staff.

The service had experienced a change in staff, with a recent high turnover of staff. There were also three staff suspended pending disciplinary investigations at the time of our visit. Staff recruitment to replace the staff who had left was underway, but the manager confirmed that they were still awaiting recruitment checks before some new staff could start work. The provider was using agency and existing staff to cover shifts, with staff records showing a high usage of agency staff on a daily basis. For example, on 11 February 2016 four agency staff had been on duty during the day and two overnight. The manager explained that where possible they used the same agency staff, to help provide some continuity of care. However, records showed that 13 different agency staff had been on duty between 8 and 12 February 2016. On the day of our visit agency staff who had been booked to work at the home had not turned up for their shifts. This meant that the service was short staffed until additional cover was provided later on in the day. To help and support the care staff who were on duty the activities coordinator and clinical lead helped provide care and supervision, rather than concentrating on their designated roles.

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

We saw that staff supervised the communal areas and provided the care and attention people needed. For example, there was always at least one member of staff in the main communal lounge for people living with dementia. The manager advised that it was now an explicit expectation that one staff member was always present in the Mews lounge to provide supervision and ensure people's safety.

We found there was no provision t for administering homely medicines. A homely medicine or remedy is another name for non-prescription medicines available over the counter in community pharmacies. A nurse commented that the lack of homely medicines had sometimes caused difficulties and described a recent situation where someone needed pain relief, but the person was not prescribed appropriate medicines at that time. This caused a delay in providing appropriate treatment to the person.
We recommend the registered person reviews this in light of the NICE guidelines: Managing medicines in care homes, which states, "It is recommended that the registered provider develops a system for the safe

use of homely remedies (taking into account the NICE Guidelines), so that such medicines are available to people who use the service when needed".

We found that medicines were safely stored in a locked room, with appropriate arrangements for storing medicines that needed refrigeration and secure storage of controlled drugs. Controlled drugs (CDs) are medicines that have special storage requirements because of the risk of misuse.

The nurse on duty was new in post and had worked four shifts to date. They told us they had been shadowed by another senior nurse during their first two shifts and had been observed administering medicines to ensure they did this safely. We observed the nurse administer medicines to two residents. They did this safely and were very pleasant, offering people explanations while giving their medicines.
Printed medicine administration records (MARs) showed personal details and clear instructions on administration requirements. There were clear protocols in place detailing how medicines prescribed on an 'as required' basis should be given. This helped to ensure that people were given medicines safely and that medicine records were accurate. The MARs we viewed showed that people had received their medicines as prescribed.

There were effective recruitment and selection processes in place. We saw evidence that appropriate checks had been undertaken before staff began work. For example, the staff files included application forms, interview records, written references and checks through the Disclosure and Barring Service (DBS). The DBS checks assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people. Checks were in place to ensure that nurses were registered with the nursing and midwifery council (NMC) and not subject to any relevant restrictions on their practice.

The service had an up to date fire risk assessment. The fire file included clear information about each resident and their evacuation plan. There was evidence that fire drills and fire training had been undertaken. For example, the three new staff whose records we checked had all completed fire training.

We looked at a selection of maintenance records. These showed that the service's premises and equipment had been serviced and inspected appropriately. Our observations during the visit showed the premises to be generally well maintained, clean and safe.

Requires Improvement

Is the service effective?

Our findings

We found examples where staff did not had the necessary skills, competence or supervision to ensure they provided the care people needed. For example, we identified failures to maintain people's skin integrity, to identify an injury and seek prompt medical attention and, to recognise and report safeguarding incidents. We were told that staff training had been DVD based, with no discussion or assessment of their competence. There was no evidence of a formal induction training programme. An induction checklist was available which included practical details covered during the first week of employment, but no formal paperwork showing what was expected during the induction period and what training each person had completed. For example, the Care Certificate [a set of standards for social care workers, which are the minimum standards that should be covered as part of induction training of new care workers] had not been implemented.

There were supervision records in the files we viewed for staff who had worked at the service for some time. However, when we spoke with staff and the manager about these records we were told that supervision had historically consisted of staff completing the supervision record themselves with little or no management input and discussion. There was no evidence of staff appraisals in the staff files we looked at and the manager confirmed there was no recent evidence of appraisals taking place.

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

The new manager had recognised the need to review and improve the training and support provided to staff. They told us that developing a competency based approach to training and supervision was one of their main priorities. An external training provider had been contracted to provide training and assessment services for the home. The manager had also consulted with external professional colleagues to request training sessions. These included a local hospice for 'end of life care' training; the tissue viability nurse; the NHS community dental team and community matron. The manager was keen to develop competency based observation into the supervision process. For example, they told us, "We want to have continual observations as a tool for supervisions, so that this becomes everyday practice; we've talked in staff meetings about the training. It's not a tick box; it's about making sure we meet resident's needs."

Staff told us that they had undertaken mandatory and statutory training. The staff files included many training certificates and a training record for all staff was provided to us during the inspection. This showed staff had completed a variety of training during the last 12 months that was relevant to their roles. We saw posters up in the reception area advertising training events that were taking place in the coming weeks. For example, safeguarding and record keeping practices.

We talked with staff about arrangements for support, supervision and appraisal. They were positive about the new manager and the support they were providing. They told us that the changes being made to training and supervision processes were positive and beneficial.

Before this inspection we had received some information expressing concern that people's nutritional needs

were not always being met. The new manager had completed a review of people's weight loss and any actions taken in response at the end of January 2016. Their review identified that 13 people had experienced a weight loss of 2kg or more. As a result the new manager had met with the chef and catering manager and ensured that a programme of high calorie smoothies, snacks and meals was in place for people at nutritional risk. The review also highlighted what other actions had been taken. For example, involvement of the GP, dietician, speech and language therapy service, and the use of fluid and diet intake charts to help monitor people's dietary intake.

A relative told us that pre-Christmas their loved one had lost their appetite and a lot of weight. They thought staff had responded well, giving the person fortified smoothies and helping to build them back up. The relative told us, "[Relative]'s put a lot of weight on. She gets exceptionally good care". This showed that the new manager was monitoring people's nutritional wellbeing and ensuring that people received support if they were at nutritional risk.

Lunchtime in the dining room for people living with dementia was a chaotic and noisy experience. Staff were very busy trying to assist everyone with their meal and the room was very cramped. They struggled to provide the attention everyone needed, despite trying hard. For example, we saw people who used the service becoming annoyed with each other, because of the noisy environment and lack of space. Staff tried to give people individual attention, but had to stop to assist other people part way through their interactions. We discussed this with the manager, who acknowledged there was room for improvement and that the dining space made mealtimes challenging. We recommend that the arrangements for mealtimes in The Mews are reviewed, to ensure that staff are able to provide the individual support people need and meal times are a relaxed and pleasant experience for people who used the service.

People told us they enjoyed the food and that the meals were good. For example, one person told us, "Bran flakes and banana [what they liked for breakfast], you can't grumble at the food, the nurses are very good, if you can't help yourself, they feed you". Relatives were also positive about the quality of the food provided. One told us, "The food is really good, there are usually two or three options."

We observed people were offered smoothies in between meals, which staff explained were, "To build people up". We also saw drinks and snacks being provided between meals. Staff were supportive and encouraging. For example, asking if people wanted another biscuit, if they wanted some more chocolate and giving one person a biscuit to eat as they walked around, because they didn't want to sit still and eat. The chef was able to explain how they catered for special dietary needs. For example, adding cream and butter to meals, providing pureed meals for people with swallowing difficulties and catering for diabetics and a vegetarian. We saw people were offered choice at the time of the meal, rather than having to choose in advance. Staff showed people the different options to help them decide what they wanted to eat and didn't give up straight away if someone refused a drink or meal.

Care records showed that people had access to other health care professionals, such as the doctor, dietician and speech and language therapist. For example, one of the records contained evidence of annual eye tests and during our inspection a dentist visited. The new manager explained how they worked with one particular local doctor's practice, which carried out routine weekly visits to people at the service. The manager had contacted the doctor's practice manager to arrange a meeting and look how they could work together to ensure that people were getting the support they needed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

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. At the time of our inspection there were 13 people with DoLS authorisations approved and in place. The manager informed us that none of these authorisations were currently subject to any conditions. A further 18 applications had been submitted to the Supervisory Body and were awaiting assessment. The manager was aware of the requirements of the MCA and when DoLS authorisations may be needed.

The individual care records we saw did not contain a lot of information relating to capacity, consent and decision making, particularly where people were subject to DoLS. We recommend that the registered provider reviews how this information is included in care planning, using guidance such as Social Care Institute of Excellence's report 'The Mental Capacity Act (MCA) and care planning' and the MCA Code of Practice.

Training records showed that all staff had completed DVD based training on MCA and DoLS. However, the manager was also looking into obtaining face-to-face training to further develop staff understanding and competence.

Good

Is the service caring?

Our findings

The majority of feedback we received from people using the service and relatives was that individual staff were caring in their approach and treated people well. For example, one person who used the service told us, "They [staff] are kind." Another person using the service said, "People [staff] listen to you, you don't feel left out, they come in to see if there's anything you want." One relative said, "Absolutely wonderful, the atmosphere is incredible, the staff are lovely." Another told us, "They're so patient with [relative]."

During our visit we observed staff being kind and attentive. For example, in the lounge for people living with dementia we observed staff supervising people and spending time with them on a one-to one basis, interacting and doing activities. Staff were patient and understanding, taking time to ask if people were alright, wanted a blanket or cardigan and offering reassurance and support. We observed they communicated with people using their names and treated them with respect. One care worker said, "They're my family I try to give the best."

A relative commented that if the staff in the lounge always behaved as they had done on the morning of the inspection, they would be delighted. They told us some staff were always very good, but that others did not interact in the same way. For example, sometimes staff just handed out drinks with little communication or there was a staff member in the lounge, but they were either doing paperwork or watching TV and not engaging with people. We were told "[name]'s always friendly and interacts, and [name] is good, but some staff… there's a body in the room but they're not interacting." This suggested a lack of consistency in staff approach, which the manager was addressing through staff recruitment and improvements to staff training and supervision.

We saw some people who were living with dementia had objects with them which they found comforting. For example, staff ensured that one lady had a baby doll and another two people had textured muffs with different materials to create sensory stimulation and comfort. There were several books around which included pictures from the past, adverts and posters. We saw staff sitting with people, engaging with them on a one to one basis, with a book or game. People were free to wander around the unit for people living with a dementia if they wished and we saw staff interacting with people in a friendly and caring way as they met in corridors or went about their tasks.

The staff we observed and spoke with understood the importance of maintaining people's privacy and dignity. We saw that personal care tasks were carried out in private and observed staff helping people in ways that helped maintain their dignity. For example, a staff member helped someone to eat in a way that maintained the person's dignity, by being patient, carefully offering small spoonful's of pureed food and wiping the person's mouth when necessary. Staff were able to describe how they would protect people's privacy. For example, by asking people discreetly if they needed assistance, closing doors and curtains so that people's care was carried out in private, and knocking on doors before entering.

Requires Improvement

Is the service responsive?

Our findings

We found following people's clinical care pathways within the home proved very difficult, due to the disjointed nature of the care plans and risk assessments. The records did not contain any 'snap-shot' pages to give an immediate and current overview of the person's state of wellbeing and needs. Care plans, although initially detailed, had not been updated to reflect the information contained in the care plan evaluations. There was a comprehensive 'Care Plan Index' at the beginning of each person's care records. However, the large number of different sections did not help to give a holistic [whole] view of the individual person, and important information that staff needed, to provide people with responsive care, was often buried deep within the records. The manager was aware of this issue and was looking at ways to improve care plan structure and recording.

We found that care plans did not identify or cover all of the information relevant to each individual. For example, one of the people we case tracked was nursed in bed and had a marked degree of limb contractures. This is a condition that can develop as a result of prolonged bed rest and inactivity. The severity of contractures can be minimised with the use of splints and passive exercises, but there were no details in the person's care plans on how staff were managing the contractures. For example, information about how staff could prevent the contractures from worsening or reduce the associated increase the risk of developing pressure ulcers. There were examples where we found that people had not received responsive care and treatment that was appropriate and met their needs. For example, failure to take appropriate action to prevent pressure damage or to seek medical treatment for an injury.

The records did not provide evidence that people, or appropriate representatives where people lacked capacity to make decisions about their care, were being involved in routine reviews or care plan evaluations. We had received concerns from a relative that staff had failed to provide them, as a relevant person and in accordance with the mental capacity code of practice, with information that they would reasonably need to understand, participate in and manage their relative's care.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Person centred care.

Before our inspection we had received feedback from two relatives about the way staff had responded to concerns and queries, both expressing the feeling that staff had failed to be open with them. Feedback from people who used service and relatives during our visit was that the new manager was approachable and responsive to concerns or issues. People also told us that if they needed to ask or remind staff about anything they were helpful and responded to their requests willingly. However, we did received feedback that things were not always followed through consistently. For example, staff would respond well to the initial request, but then fail to ensure that the requested improvements or changes continued in the future.

Information about the complaints process was displayed and the manager showed us the complaints record. This showed that three complaints or concerns had been raised since November 2015. The actions taken to resolve two of the concerns were recorded, with the third being dealt with by head office and as yet,

unresolved. There was also a record of compliments received by the service. There was no record of any concerns or complaints available pre November 2015. We were aware that concerns were raised by relatives in September 2015, but there was no record in relation to these or the actions taken. The manager confirmed that they had been unable to locate any records relating to complaints or concerns pre November 2015.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Receiving and acting on complaints.

Each person living at the home had their own care individual records. These contained assessments, risk assessments, care plans, evaluations and other records relating to their care. The records we looked at contained some good, detailed and person centred information about the person and their needs. For example, one person's life history included information about them liking to be smart, with manicured nails, but no make-up.

The majority of feedback received from people and relatives about the service and care they received was positive. A relative explained, "The nurses have always been responsive, there's a couple who are extremely caring and [activity coordinator] is extremely good." Another relative told us how staff understood that their loved one was deaf in one ear. They said, "Staff always lean down and speak to [relative] on that side." When we spoke with staff they were aware of this person's needs and told us that this person could hear better if you spoke on their right side.

From the discussions with staff, it was clear that people were supported to make choices. For example, staff said they would seek people's consent before any activity or intervention, and we observed people being asked what they would like to do, whether they would like a blanket and what drinks or food they would like. One person told us they liked to go to bed at a certain time and this was supported.

People we spoke with were all positive about the activity coordinator and their contribution. One relative said, "[Name of staff member] makes a wonderful job of every day, they had a lady singing love songs." One relative described how there was, "Always an abundance of activities". They particularly liked how staff let their loved one help with useful tasks so that they had a sense of purpose, "They let her help out with the laundry." Another person told us, "There's always something going on, they had animals in here including a donkey." Relatives confirmed that they could visit freely and were made welcome. Staff had helped one family arrange a party in the quiet lounge for their relative's birthday so that all the family could be there to celebrate together. Monthly activity programmes were displayed and showed a variety of activities and events taking place in both units. For example, games, baking, massage, walks, church services and flower arranging.

We talked with the activities coordinator and they explained that they liked to have a range of different things going on, with external entertainers to celebrate events. They worked flexibly, including some weekends. For example, on the previous weekend, which was Valentine's Day, they had worked on the day itself. All the ladies had been given red roses and there had been a singer who performed on both the nursing and dementia care units. There were still Valentines 'decorations' displayed throughout the home. The activity coordinator talked with everyone as they supported them and referred to their family members and life events. For example, chatting with two people about the birth of great grandchildren. They had also borrowed films from the Yorkshire film archive, for people to watch and create topics for discussion and reminiscence.

Requires Improvement

Is the service well-led?

Our findings

The Commission had not always been notified about incidents that the registered provider had a legal requirement to tell us about. Incident records we viewed indicated we had not been notified of five potential safeguarding events or a fall that resulted in a serious injury during August and September 2015. We are pursuing this separately with the provider. We spoke with the new manager about notifications. They were able to describe notification requirements and we found that we had received appropriate notifications during late 2015 and so far during 2016.

Two senior care staff told us that staff morale was low. The reasons given were changes in management and staffing that had occurred recently and the on-going safeguarding and disciplinary investigations. Senior staff felt they were working and trying hard to make improvements, but that the on-going investigations into past failings made this difficult at times. Senior staff were clearly under pressure and in need of on-going support to ensure that they could achieve the changes that were required.

We spoke with the manager about the senior management support currently in place. They confirmed they had a new area manager, but their input had so far been limited to support with the on-going safeguarding and disciplinary investigations due to the issues within the home. At the time of our inspection the manager had no clinical nursing oversight from senior management. The provider had recognised the need for clinical oversight and support at this service and was currently advertising for this role.

Our inspection findings indicated that governance systems at the home had not always been effective. Up until December 2015 the previous area manager had completed monthly quality visits and reports, but no such reports were available after this date. The manager was able to tell us what they saw as the service's main priorities for improvement and what they were doing about these. When we asked to see a formal action plan one was not available, although the manager acknowledged that this was something they needed to develop.

Quality assurance systems were in place, which included a routine of audits, checks and quality returns completed by the manager. We saw the most recent records which had been completed in January 2016 by the new manager. A resident and relative's meeting was planned for Friday 19 February, and we saw signs in the reception area advertising the event. We asked to see the minutes from previous meetings, but there were none available. The new manager had a staff meeting plan in place for 2016, showing regular scheduled staff meetings. We were also shown the staff meeting records for two meetings that had been completed by the new manager since they came into post. These showed that staff had been reminded of safeguarding processes, record keeping standards, new staff training and supervision arrangements and other relevant information. We asked to see evidence of previous staff meetings, but were told that previously regular staff meetings had not taken place.

Staff told us that historically there had been a culture of "sugar coating" and "hiding" things at the service, rather than being open and honest about things that had gone wrong or needed to improve. Records were not available to show that complaints, concerns or safeguarding issues had been appropriately responded

to, previous to November 2015. We found examples of incidents that occurred during 2015 that should have been reported to the local safeguarding team and the Commission but had not been. We had also received feedback from two relatives about what they felt was the lack of an open response when they raised queries or concerns about their loved one's care.

We found example's where care records were not of sufficient quality. Care records were not always complete, and we found examples that were illegible or inaccurate. There were gaps in care records that made it impossible to know if people had received the care they needed or to monitor and respond to people's care needs promptly. For example, one person was supposed to receive three hourly positional changes which were recorded on their observation chart, but the records were not complete. Charts that were used to monitor people's fluid intake were not consistently or accurately completed. For example, one person's charts showed unexplained gaps in recording and had been totalled incorrectly. Body map records were not consistently used to show and monitor when someone had injuries or wounds. For example, one person had a body map in place which showed some of the injuries and wounds they had sustained, but not others. One record had been altered in an inappropriate way.

The way care plans and evaluations were recorded meant that it was very difficult to get a clear picture of the person's up to date care needs. For example, care plans had been written and included some good, detailed information about people, but the care plans themselves had not been updated when things changed. The only way to make sure you had an up to date and complete picture of the person and their current care needs was to read the original care plan and all of the evaluations that had taken place since. This was often pages of hand written information, which was sometimes difficult to interpret and not always in the correct chronological order. This meant that up to date information about people and their current care needs was not easily accessible.

The service had archived all care records at the end of the year. This created difficulties when trying to track and follow people's care into late 2015. Obtaining the records we needed was difficult, with large amounts of records that staff had to search through to find the relevant documentation.

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

The service had been through a period of management instability. Between June 2011 and December 2015 four different registered managers had been in post. At the time of this inspection the service did not have a registered manager, with the previous registered manager having left the service and de-registered in December 2015. The new manager had been confirmed in post during January 2016. After our visit we received a valid application and the new manager is now registered with us.

The majority of feedback we received from people who used the service and their relatives was positive. For example, one relative told us, "It's excellent…… This is the third home [name]'s been in and it's the best." People and staff told us that the new manager was well thought of and positive changes were being made at the service.

The new manager appeared honest and open during the inspection, acknowledging that the service had problems and coming across as committed to making improvements. They welcomed the inspection and saw it as a tool to help them make the needed improvements. Staff and relatives spoke positively about the new manager and the changes that were happening at the service. People told us that the manager was approachable and that they could discuss concerns with her or other members of the team. For example, when we asked one staff member told us, "We work as a team, it's a lot better, [name of manager]'s a really

good manager, a lot of people weren't happy, but there's a big change and the caring side has improved."

The new manager and clinical lead told us that they had experienced resistance to change from the existing staff group, with a number of staff leaving. New staff had been employed, which the new manager saw as a positive, because it had allowed them to reshape the staff team and start developing a more open and responsive culture.

At the time of our visit the manager informed us that the service no longer used some of their bedrooms as double rooms, meaning that their maximum occupancy was now 44. We discussed the need for the service to update their registration to reflect this during our inspection.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment had not always been provided in a safe way for service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users had not always been protected from abuse and improper treatment. Systems and processes had not been operated effectively to prevent abuse or to investigate any allegation or evidence of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered person had failed to operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons had not always been deployed. Persons employed had not received the necessary support, training and supervision to enable them to carry out the duties they were

employed to perform.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment provided to service user's had not always been appropriate or met their needs.

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes had not been operated effectively to assess, monitor and improve the quality and safety the services provided, to assess monitor and mitigate the risks relating to the health, safety and welfare of service users, or to maintain an accurate, complete and contemporaneous record in respect of each service user.

The enforcement action we took:

We issued a warning notice.