Bupa Care Homes (GL) Limited

Burley Hall Care Home

Inspection report

Corn Mill Lane
Burley In Wharfedale
Ilkley
West Yorkshire
LS29 7DP

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31 August 2017

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 8, 18 and 31 August 2017 and was unannounced. The previous inspection had taken place on 5 January 2017 and at that time we found the provider was in breach of Regulation 17: Good Governance and Regulation 18: Staffing.

This inspection was carried out to see what improvements had been made since the last inspection. During the current inspection we found the provider was in breach of nine regulations again including the two regulations already proven at the last inspection. The current breaches are: Regulation 9: Person Centred care; Regulation 10: Dignity and respect; Regulation 11: Need for consent; Regulation 12: Safe care and treatment; Regulation 13: Safeguarding service users from abuse and improper treatment; Regulation 14: Meeting nutritional and hydration needs; Regulation 17: Good governance, Regulation 18: Staffing and Regulation 19: Fit and proper persons employed.

Burley Hall Nursing Home is located in Burley-in-Wharfedale near Ilkley and provides nursing and personal care for up to 51 older people, some of whom are living with dementia. There were 42 people using the service when we visited. Accommodation is provided in two houses and during the current inspection Greenholme House was accommodating 16 people living with dementia and Wharfedale House was accommodating 26 people with nursing needs. There are communal areas on each house and access to garden areas.

At the time of our inspection the service was without a registered manager. The manager was going through the Care Quality Commission (CQC) registration process. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Whilst people and relatives generally shared positive experiences about the home and said good quality care was provided for the most part that met people's individual needs, there were several areas within the home which did not meet the required standards. During the last inspection we found low staffing levels and poor staff morale and at this inspection we found these issues had still not been addressed effectively. Staff and people who used the service told us there were not
enough staff to keep people safe at all times. We identified this as a continued breach of regulation.

Furthermore with regard to staffing, the staff members spoken to at this inspection told us they were not adequately or consistently supported. Whilst staff were up to date with training on safe working practices and recruitment records demonstrated there were systems in place to employ staff who were suitable to work with vulnerable people; recruitment procedure was not always followed and there were not sufficient numbers of staff hired to meet the needs of people living in the home. With regard to staff supervision the regional director told us the service was trying a new supervision system where supervision is held when staff request or when management feel there is a need.

People told us they felt the service was safe and staff spoken with had a good understanding of safeguarding and knew how to report any concerns about people's safety and welfare. However, we found management had not reported all safeguarding concerns to the local safeguarding team and the CQC. We identified this as a breach of regulation.

We found people's medicines were not managed safely. Records showed creams and lotions known as 'topical medicines' were not applied as prescribed. We also found people had received their night medications well before the recommended time. We identified this as a breach of regulation.

We found staff were not working in accordance with the Mental Capacity Act which meant people's rights were not always protected.
Staff were able to tell us how individuals preferred their care and support to be delivered. However, they were not always able to ensure that people always respected each other's privacy.

Apart from issues with diet/nutrition we found people's health care needs were met and relevant referrals to health professionals were made when needed.
We found evidence that care plans were not always being monitored to mitigate risks to people who used the service. There were several care plans not being followed to ensure people's skin integrity was maintained.

We found information detailed in care records to be very variable with some containing a good level of person centred information and others requiring further personalisation to reflect people's personal preferences. We have made a recommendation about consistency of care records.

People were offered a varied diet and were provided with sufficient drinks and snacks throughout the day. However, we found some people had suffered weight loss and this was not being adequately managed.

Feedback about activities available within the home was poor. Staff and people who used the service told us more could be done in this area. Although there was information about people's interests and hobbies in some care plans, we did not see this being followed through to ensure people were supported to maintain these interests.

Although there were systems in place to ensure complaints and concerns were fully investigated, people who used the service as well as staff reported that these were not always addressed effectively.

We found some areas of the home and equipment were appropriately maintained and we noted safety checks were carried out regularly. However, although we found there were systems to assess and monitor the quality of the service, which included feedback from people living in the home and their relatives; these quality monitoring systems had not been effective in achieving the required improvements in the service. This showed us that the governance systems in place were not productive and required further amendments and upgrades in order to ensure progress at the home would be developed. We raised concerns about staffing at the previous inspection and this had still not been acted on.

You can see the action we have asked the provider to take at the back of the full version of this report. We found the overall rating for the service is 'Inadequate' and therefore the service is 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, then 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.

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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People told us they felt safe; however safeguarding procedures had not always been followed.

There were not always sufficient numbers of staff hired to meet the needs of people living in the home and keep them safe.

People were not always supported with their medicines in a safe way by staff.

Care plans were not being followed to mitigate risks to people who used the service.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not always working in accordance with the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

We found peoples food and fluid intake was recorded but action was not always taken to when weight loss accrued.

The provider offered a five day induction training. However we found there was a lack of planned and consistent approach to practical induction.

Is the service caring?

Requires Improvement

The service was not always caring.

People were supported by staff that were caring and compassionate and who knew about their individual likes, dislikes and preferences.

However, we found privacy issues for people using the service were not always being addressed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care practices were not always person centred to reflect people's individual needs.

We received poor feedback about activities in the home. People we spoke with as well as staff felt more could be offered.

The provider had a complaints procedure which clearly outlined how concerns would be managed. However, people who used the service, relatives and staff spoken with told us they felt any concerns highlighted were not always taken seriously by the management team.

Is the service well-led?

Inadequate

The service was not well-led.

Staff we spoke with told us the manager did not listen to them and morale was low.

At the time of inspection there was no registered manager in post.

There were systems in place to monitor the quality of the service which included feedback from people living in the home and their relatives. However the systems were not robust enough to ensure people received safe, effective and responsive care and treatment.

Burley Hall 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 8, 18 and 31 August 2017. The inspection was unannounced on all three days. On the first day the team consisted of two adult social care inspectors and an expert-by-experience. An expert-by-experience is an individual with experience of using or caring for someone who uses this type of care service. On the second day, the team consisted of three adult social care inspectors and on the third day the team included two adult social care 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 and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care service in England.

We had asked the provider to complete provider information (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was sent to us in July 2017.

During the inspection we spoke with the home manager and two regional directors. We spoke with a regional director from one of the provider's other regions on the second day of the inspection who was supporting the home manager in the absence of the regional director responsible for this service who was spoken with on the first day. We also spoke with the deputy manager, the house manager, 14 care staff, activities staff, housekeepers, laundry staff and kitchen staff. We spent time speaking with 14 people who used the service, five visiting relatives and a visiting professional.

We looked at records relating to people's care and support including 14 care plans, medicines administration records, audits, accidents and incident records, complaints and compliments, maintenance

and staff recruitment. We also spent time looking around all areas of the home including communal areas, bathrooms, toilets, some people's bed rooms, laundry and the kitchen.

Inadequate

Is the service safe?

Our findings

At our last inspection in January 2017 we rated this key question as 'requires improvement.' We found staff were not always deployed to keep people safe and we identified a breach of regulations relating to staffing and asked the provider to make improvements. In addition to staffing, some aspects of medicines management were not always safe. At this inspection we found improvements had not been made. The provider still remained in breach of the regulations relating to staffing.

People told us they felt safe living at Burley Hall. Comments included, "I feel safe, very safe," "People are nice, I feel safe." "I have never seen anything to make me feel unsafe." Relatives we spoke with told us they felt their family members were safe using the service.

In the PIR the provider told us, 'Staff are aware who to report to should their line manager be involved with the abuse. Any accident, incidents, abuse and potential abuse that could harm or potentially harm our residents will be reported through our reporting documentation.'

We saw there were safeguarding policies and procedures in place and these were also on display. We spoke with two members of staff about their understanding of safeguarding and what they would do if they thought people who lived at the home were at risk. Both of them told us they would not hesitate to report any concerns to the manager, CQC or the Local Authority Safeguarding Team (Safeguarding).

However, we found safeguarding procedures had not always been followed. Firstly, we found a report from a member of staff which was addressed to the manager, providing details about a safeguarding issue. We saw this had not been referred to Safeguarding. We asked the manager about this. They told us they had spoken with the member of staff to determine their level of concern but had not spoken to Safeguarding or made a referral to that team. This showed a lack of understanding of the safeguarding process.

Secondly, we found a Transfer Form Summary for the 13 August 2017 in a care file. We spoke with the senior care assistant who informed us this was used when someone was taken to hospital. Through conversation with the senior care assistant they told us an individual had fallen and fractured their Clavicle (shoulder bone). Senior care staff informed us they did not know how this had occurred. We could find no record in the daily notes of the reason for hospital admittance. No Accident/Incident form or safeguarding form was completed or notification made to CQC. This showed a lack of understanding of the safeguarding procedure.

We saw other examples which may have become safeguarding issues because of the lack of staff supervision. One example noted took place in Greenholme House where we heard one person who used the service refer to another person using foul and abusive language. Though staff intervened quickly to diffuse the situation; later on, we saw the same two people in the corridor and one person tried to push the other over.

Another example occurred on the second day of the inspection when we saw an incident recorded by day staff where one person who used the service had not been repositioned by the night staff at the required frequency. Prolonged periods in one position can result in tissue damage and discomfort for people and for those people who lack independence and are unable to turn and reposition themselves, care staff will need to do it for them. Day staff had noted the person had a rash as their continence pad had not been changed. We asked the House Manager at Greenholme as well as the Manager if this incident had been referred to safeguarding. They told us it had not been. When we spoke with the regional director they agreed a referral to safeguarding should be sent. A referral was made on the same day.

In addition to the above safeguarding concerns, we also found the manager was not notifying CQC about occurrences as they are required to do. We found Accident/Incident records were completed, but these are not always followed through using the correct procedure. We identified that some of the accidents/incidents should have been reported to Safeguarding and to CQC. These included the following which had been recorded in the Accident/Incident File:

5 August 2017: "Individual found on the bedroom floor as they had got out of bed at the opposite side of the bed to their pressure mat and fell. Injury to both shoulders and left leg. All wounds were measured and photographed. This was referred to the GP who advised transfer to Hospital".

10 August 2017: "In the dining room one individual was shouting and swearing at another across the dining table. One individual then pushed the table into the others ribs, the other individual then pushed back and both started swearing at each other. No visible injuries sustained".

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

We asked people and relatives who used the service if they thought there was enough staff on duty to support people. Comments included, "My concern is the ratio of staff to residents." We asked how this was manifested in terms of care and the person answered, "For example, there are a group (of residents) sitting in here and there is a lack of staff available to sit and talk (to them)." "We are aware that there are staffing issues; a sizeable number (of staff) have left." "We've seen residents in the dining room taking time to finish their meal. Staff are not always there to respond nor are they in the vicinity, there is often no-one in attendance." "Weekends not as good as during the week. Weekends are abysmal, there are not enough staff. Some days, the bed isn't made until 5 pm. It's (the home) been stripped of staff." "I sometimes think they are understaffed. At weekends they have temps and agency staff. I don't think the agency staff understand the systems. The regular staff understand the needs of the residents. When temporary staff come in, they don't know the residents. They are agency staff on fairly frequently on a weekend."

We found there were not enough staff to keep people safe.

We spoke with care staff on both houses who all told us there were not enough staff to provide people with safe care. Their comments included, "There are not enough staff and I get behind with my work." "We need more staff and a nurse on each shift." "The manager is looking at numbers of people living here and not their dependency. Staff get stressed when there are not enough of them. Sometimes breakfast doesn't finish until 11:00am and if agency staff are working it's even more difficult. Some agency staff don't want to come back."

During our visit on 8 August 2017 we saw people on Greenholme House going in and out of each other's bedrooms. No staff were available to redirect them or to offer taking part in an activity and/or companionship. During the afternoon we saw one care worker offering support to one person in the lounge;

whilst the staff member was doing this, another person who used the service was touching someone else's sandwiches and re-arranging the food on their plate. There were no other members of staff available to intervene. On 18 August 2017 we saw one person sitting in another person's bedroom at 10:35am. We concluded there was not enough care staff on duty to keep people safe during the day.

On 8 August 2017 at Greenholme House there were two members of waking night staff. We spoke with them and they told us during the night one of the people who used the service had broken off the storage area on top of the nurse's desk. On another occasion at night, we saw recorded in the daily records that when two night staff came back from doing their rounds they found a male service user going into other people's bedrooms. The same night there was also another incident when the male service user did not want to leave a bedroom and began banging and pushing the door. Staff had to press the emergency buzzer to get a staff member from the other house to assist them. This person's care plan stated 'staff to be aware of [Name's] whereabouts at all times.' This was not possible with only two staff at night. In addition, the bedroom accommodation on Greenholme House is over two floors which meant if staff were upstairs there was no one to supervise the ground floor, which potentially left people at risk.

Following the first day of inspection on the 8th August, the manager was spoken to about staffing after we looked at the duty rotas. When we returned to the home on 18 August 2017 the manager told us they had increased the night staffing on Greenholme House from two to three staff.

On Wharfedale House we also found there were not enough staff to deliver care and support in a timely way. One relative told us after the tea time meal, care workers put people to bed at the same time every evening as this was the only way they could manage to get all of their tasks completed. We found evidence of people not being repositioned, which is necessary to ensure the risk of pressure ulcers developing are minimized, and staff told us it was because there was not enough of them to undertake all duties.

Staff told us sometimes there was a nurse on both houses during the day but sometimes there was just one nurse in the building and a senior care worker would be in charge of one of the houses.

We asked the manager how they decided when two nurses were required and when only one nurse was needed. They told us it was about availability, needs of the home and skill mix. However, we could find no clear rationale for this and no other explanation was offered.

Burley Hall has 48 bedrooms, communal areas, toilets, bathrooms and shower rooms. We spoke with two of the housekeepers who told us during the week there were two of them on duty to keep the home clean. However, at weekends there was only one housekeeper on duty for the home.

We had raised staffing levels as a concern at our last inspection, and identified this as a continual breach of regulations. We concluded the provider remained in breach of Regulation 18 (1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment files of some members of staff. Files should contain application forms, evidence of answers given at interview which showed the person's suitability for their role, background checks such as references from former employers and confirmation of identity and checks with the Disclosure and Barring Service (DBS). The DBS is a national agency which holds information about people who may be barred from working with vulnerable people. DBS checks help employers make safer recruitment decisions.

On 8 August 2017 a care worker told us a newer member of staff was working, but had not received their DBS

check. We spoke with this member of staff who confirmed they had not received their DBS check.

However, during our visit on the 18 August 2017, eight staff files were checked. In one of the files references were missing. One staff member's DBS was missing from the file, even though their employment had commenced on the 31 July 2017. During the visit and after speaking with the manager, the DBS was printed off and added to the file of the staff member. We spoke with the regional director who confirmed the manager should always check all information is present prior to an individual starting work. This confirms a breach in procedure as the manager had not followed company guidance.

This was a breach of the Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records for people who used the service contained identified areas of risk. Risk assessments were in place which covered; for example, moving and handling, nutrition and tissue viability. However, we found evidence that some care plans were not being followed consistently to mitigate risks to people who used the service.

In one instance we saw from the records one person had developed a pressure sore on one of their heels. Their care records showed they needed to be repositioned every four hours. We looked at their repositioning charts and saw on the two days prior to the sore being discovered, they had not been repositioned at four hourly intervals. We saw they had a specialist air mattress on their bed, which was on setting two. We asked the clinical services manager if this was the correct setting and they were unable to confirm this. The regional director went to check and confirmed for the person's weight the mattress should have been set at three to four. If pressure relieving equipment is not on the right setting it would lose its therapeutic value and could cause further damage or prevent the sore from healing.

In another person's care plan, we saw they needed to be repositioned every two hours as they had been assessed as being at risk of developing tissue damage. We looked at their repositioning charts and saw on two days there had been 7 hours and 7 hours 25 minutes between repositioning.

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

We inspected medication storage and administration procedures at the service. We found medicines were stored securely in a locked treatment room and access was restricted to authorised staff. There were appropriate arrangements in place for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse); these were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. We saw drug refrigerator temperatures were checked and recorded daily to ensure medicines were being stored at the correct temperatures.

We observed the morning medication round and the qualified nurse on duty administered the medicines correctly and asked if people required medicines administered on an 'as and when required' [PRN] basis. The records we looked at showed under what circumstances PRN medicines should be given.

We looked at medication administration records [MARs] and reviewed records for the receipt, administration and disposal of medicines. We found on all occasions the medicines could be accounted for. However, during our visit on the 18 August 2017 a staff member informed us they had found medication (tablets) on three separate occasions. Once on the floor in a blister pack near the nurse's station, on another occasion in

an individual's bedding and lastly, on a bedroom floor. This suggests that people were not receiving their prescribed medication. It also indicates that when medication was being dispensed that people were not being adequately supervised to ensure that they have swallowed the given tablets. This is clearly an impact on their health needs and suggests limited management of medication.

We looked at the topical medication administration record [TMAR] and found body maps were in place to ensure staff applied the cream or ointment to the correct area. However, we found one person's medication cream was to be applied twice a day from 02/06/2017 and records showed this had last been applied on 04/07/2017. This was discussed with the deputy manager who later found the cream for that person in the medication room. This meant the person had not received their medicines as prescribed.

We asked people who used the service how their medicines were managed. One relative told us, "Communication systems. Between the home, the GP and the pharmacy, it falls down." They said their relative needs cream for their skin and there had been a time delay of two weeks since the GP prescribed the cream and the cream had not yet been obtained by the home. They went on to explain why their relative needed the cream. "She needs it four times a day. She has an infection and if she will get the antibiotics tonight; that works well, but sometimes nothing seems to happen. I'm not sure where in the chain the problem is." We asked the nurse about the person's cream. The nurse showed us records which indicated that the cream was now in use.

We found in an individual's daily notes an entry dated 13 August 2017; 'Doctor from out of hours contacted due to a lot of discomfort from individual. Discovered their Morphine Sulphate was out of date so requested a stronger pain killer.' The service should ensure people's medications are always in date.

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

We saw that at the last food standards agency inspection of the kitchen they had awarded the service a 5* rating for hygiene. This is the highest award that can be made. This showed us effective systems were in place to ensure food was being prepared and stored safely.

We found the home clean, tidy and odour free. We saw staff had access to personal protective equipment; such as gloves and aprons and were using these appropriately. The housekeepers told us part of their checks included making sure there were aprons, disposable gloves, soap and paper towels available.

We inspected maintenance and service records for gas safety, electrical installations, water quality and fire detection systems and found all to be correctly inspected by a competent person. We saw all portable electrical equipment had been tested as required. Each person also had a personalised evacuation plan for use in the event of an incident such as a fire.

Requires Improvement

Is the service effective?

Our findings

We looked at staff records and the training matrix. We saw training was either completed, booked, or in the process of being signed off as completed. Staff were required to complete a number of courses including fire safety, moving and handling, infection control, safeguarding, health and safety, nutrition, dignity and respect. Staff we spoke with told us their training was kept up to date.

The provider offered a comprehensive five-day induction which included training on a range of subjects such as moving and handling, fire safety, infection control, health and safety, nutrition and pressure ulcer prevention.

We spoke with a new member of staff who had completed their induction training and was working their second day 'shadowing' more experienced staff to give them practical experience. We asked them if they were 'shadowing' the same member of staff on the same unit. They told us they had worked on Greenholme House on the first day and were on Wharfedale House when we spoke with them and told us they had been 'swapped' between a number of care staff. Another new member of staff told us on their first shift they were supposed to be 'shadowing' another member of staff but had been involved in delivering hands on care. This showed us there was a lack of a planned and consistent approach to practical induction.

We asked staff if they received supervision and felt supported in their role. These are some of the comments made by staff: "I had group supervision last week with four other people. I would prefer to have supervision on my own." "I have had no supervision this year." "I have had only one supervision." "Supervision is used to tell you off." "In group supervisions everyone would be told off for not completing paperwork correctly, although it might not apply to all the staff at the meeting." Staff told us annual appraisals take place. The regional director told us the service had replaced supervisions with a new system of performance conversations that take place regularly during an employee's time at work. The conversations are instigated either by the staff member or their line manager. The line manager then uses their discretion regarding which conversations to capture for future reference.

In the PIR the provider told us: 'All relevant staff are trained within the Mental Capacity Act 2005 and mental capacity assessments are in place for those individuals where there are concerns about their capacity to make decisions".

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 authorisation 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. Staff told us they had received training in the MCA and understood when people lacked capacity; decisions had to be made in their best interests. Staff reported that they had completed DoLS training and understood that these safeguards protected people.

We saw one person was receiving their medicines covertly (disguised in food). The best interest process had been followed involving the person's GP, a psychiatrist, pharmacist, clinical services manager and relative. The decision to do this had only been made after all other options had been explored; for example, liquid medicines. This showed us in this example staff had followed the correct process.

We saw one DoLS authorisation had three conditions attached to it. However, the care plan did not contain any evidence about how these conditions had been addressed. This meant we could not be assured these conditions had been adhered to.

We asked the manager if they had a record of any Lasting Power of Attorney (LPA) which was in place. A LPA is a legal document that allows someone to make decisions for you, or act on your behalf, if you're no longer able to or if you no longer want to make your own decisions. LPAs can be put in place for property and finance or health and care. The manager did not have a central record of any LPAs which were in place. We looked in one care file and saw a relative had a Lasting Power of Attorney (LPA) order in place in relation to property and finance, although we could not find a copy of the LPA to confirm this was the case. We saw this relative had been making decisions about this person's health care, which they did not have the legal authority to do. For example; the person's relative stated they didn't want any intervention of the person's swallowing other than thickened fluids and pureed diet.

This was a breach of the Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people who used the service about the meals provided. These were the comments people made: "The food is very good." "The food is very good. I had salmon with dill sauce and chocolate pudding with hot custard." "At teatime you still get a choice; soup, a choice of sandwiches, you can choose your own filling. Tonight it's tuna and mayo; I can choose; there is a choice. We can have fresh fruit in the afternoon." "The meals at tea times are a bit repetitive. They have pastry such as sausage rolls about two or three times a week. It has improved a bit but there is a lack of variety."

We saw people were offered a drink and biscuits when they got up in the morning. At breakfast people were offered a choice of cereals, porridge, a cooked breakfast, and toast with jam or marmalade and hot and cold drinks.

Mid-morning and mid-afternoon drinks and a selection of snacks were on offer such as biscuits, fruit, cakes and full fat yogurts. Staff told us they could get people snacks and drinks at any time if they wanted them.

At lunchtime there was a choice of meal on offer consisting of either salmon or liver. People were verbally offered a choice but no one was shown the two meals which would have made it easier for people to have made an informed decision. The meal time hostess did show one person the choice of desserts and they chose both and were given both.

We saw some people required assistance from staff with their meal and although this was given with patience and kindness staff did not explain the type of meal/ingredients to the individual. We did see that a

member of staff had to stop assisting one person in order to support someone else.

One member of care staff told us people were losing weight because staff did not have time to support them with their meals. Another member of staff also told us staff did not have time to assist people with their meals and drinks.

We saw one person had been losing weight since April 2017; however, when the care plan had been reviewed staff had written, "Weight is now stable, appears to be enjoying her food more and appetite has improved." We saw that person's food and fluid intake was being recorded but no action in relation to the total weight loss of 3.8kg had been taken. The regional director confirmed a referral to the GP and/or dietician should have been made.

This was a breach of the Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the cook and found they were knowledgeable about people's individual dietary needs and worked with the care staff to ensure people received a healthy and balanced diet. They told us they were aware of the need to fortify food for people experiencing weight loss and followed the 'Guide to fortifying common food.' They also told us if people did not like what was on the menu they were always offered an alternative.

We asked staff if they thought people's healthcare needs were being met. Staff told us if they had any concerns the nurses were quick to respond and would arrange for GPs or other relevant healthcare professionals to visit. One care worker said, "Healthcare is really, really good."

Apart from issues with diet/nutrition people had been seen by a range of health care professionals; including GPs, specialist nurses, opticians and podiatrists. Care records contained details of advice given following any visits.

We saw staff had received training in end of life care and saw 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) forms were completed appropriately and had been discussed with people who used the service and/or their relatives and signed by relevant professionals.

Requires Improvement

Is the service caring?

Our findings

In looking at the service in relation to policies and procedures we found privacy issues for people using the service were not always being addressed. For example, in one person's care plan we saw recorded, 'Allow [Name] to walk around the unit if they go into other residents' rooms; observe what they do, if needed gently guide them out.' We saw people walking in and out of one person's bedroom on a frequent basis. We asked a care worker about this and they told us people were particularly attracted to this room. The house manager told us people liked to congregate in that particular bedroom and though this showed a lack of respect for the person's individual space, there were no plans to show how this was to be managed by staff. We noted the bedroom doors had 'single action' type locks in place and this meant if the door was locked from the outside the person in the room would not have needed to unlock the door to get out and would only have had to push the handle down to come out of the room. This meant it was possible through risk assessment to ensure people's privacy could be maintained.

When we arrived on Greenholme House on 8 August 2017 we saw one person was asleep on a mattress on the floor of the quiet lounge. The house manager explained this was because they did not like going upstairs to bed and had been sleeping on a small two-seater sofa in the main lounge. The house manager told us they had asked for a camp bed but the manager had told them to try a mattress on the floor first. We saw this person was asleep all morning and during this time a number of people who used the service walked into the quiet lounge and sat down, affording the person who was asleep no privacy. We discussed the inappropriateness of this arrangement after our first day of inspection and noted there was a vacant single bedroom on the ground floor. On the second day of inspection the person had moved into the single vacant bedroom and the manager and staff told us the move was working well.

We observed that a nurse came into the dining room and put a tray and sharps box on the dining table where three women were sitting; two of whom were eating their breakfast. The nurse then administered one person's insulin. This showed a lack of sensitivity and little regard for the person who had their medication dispensed in sight of others as well as being inconsiderate towards those who were having their breakfast.

One person had been left sitting in their wheelchair alone in the lounge, no staff were present. Their skirt had not been pulled down properly and they were exposing their abdomen.

This was a breach of the Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the service had policies and procedures in relation to protecting people's confidential information which showed they placed importance on ensuring people's rights, privacy and dignity were respected. The policies highlighted the need for people to be treated with dignity and respect and maintaining their independence however in practice this was not always apparent.

In the PIR the provider told us, 'Staff build up close supportive relationships with the residents they provide care for, and their family and friends'.

Members of staff spoken with told us they provided people who lived at the home with good care. Staff were able to tell us how individuals preferred their care and support to be delivered. They explained how they attempted to maintain people's dignity, privacy and independence although staff were not always able to ensure that people always respected each other's privacy. For example; whilst staff told us about the importance of knocking on doors before entering people's bedrooms and making sure curtains were closed when supporting people with personal care, they did not always prevent people entering another person's bedroom without permission from that person.

We saw people looked well dressed. For example, some women were wearing jewellery and had their hair styled and the men were shaven. This indicated to us that staff had taken the time to support people with personal care in a way which would promote their dignity.

The home was considered by people living there and their relatives as caring. Typical quotes included, "Yes, they are kind and caring and are all very pleasant." "Staff are very, very good with him. They are busy but if he needs anything, they get things for him." "They are excellent. I couldn't find fault with them, they are lovely with the residents." "The carers are dedicated but are worked to the bone."

We observed people in the lounge/dining area for around 20 minutes over the late morning period. There were four people in the room and three of them were watching television. No staff were present but after 5 minutes, a member of staff entered the lounge. The staff member was pushing someone in a wheelchair. The staff member was gentle and pleasant with all the people and though we noticed they made a space for the wheelchair and slotted the person in the space, the member of staff had not asked the person where they wanted to be. However, another staff member brought in another person and they did ask them where they wanted to be placed. They called the person by their first name and introduced them to the other people in the group. Another member of staff brought in another person but they did it very quickly and didn't ask the person where they preferred to be seated in the room. We concluded there were mostly good interactions between staff and people who used the service with a few small areas for improvement.

We saw the care plans for people who used the service contained 'Life history' information and details of their interests and hobbies. Care plans contained information about people's advance wishes, sometimes known as end of life care plans. This meant if someone suddenly became seriously ill, staff would know how the person would want to be cared for. For example, some people may prefer to stay at Burley Hall for end of life care, rather than being transferred to a hospital or hospice.

Staff told us people's diverse needs in respect of the seven protected characteristics of the Equality Act 2010; including age, disability, gender, marital status, race, religion and sexual orientation were met where applicable. We saw no evidence to suggest that anyone who used the service was discriminated against and no one told us anything to contradict this.

Requires Improvement

Is the service responsive?

Our findings

We spoke with people visiting the service. One relative told us that after the tea time meal, care workers had a set routine and people went to bed at set times as this was the only way they could get through the work. They added it was very difficult for them to deviate from this routine. However, in discussion with people they told us they went to bed when they wanted and got up when they wanted.

One visitor explained their relative had a urinary tract infection and that it was the sixth consecutive one. They had managed to get a urine sample the day before but staff had been unable to test it as no 'dip sticks' could be found on either unit. We saw 'dip sticks' were available and staff told us they had been there the previous day but had been overlooked. This meant no treatment had been obtained for the person to treat the suspected infection. The manager was spoken to about this person and commented that they "would look into it".

Some people we spoke with told us they had to wait up to half an hour for staff to respond to their call. We asked the manager for a print out of response times to emergency call bells so we could see how responsive staff were. We asked the manager what their expected response time was and they were unsure. The regional manager told us there was nothing in writing but they felt 3-4 minutes would be acceptable. We saw the majority of calls were responded to in a timely way; however, there was some variation on the timing of the responses with some calls taking over 20 minutes to be responded to. The manager stated they would look closer at this.

Staff we spoke with told us there were not enough activities on offer to keep people occupied and we agreed with their observations.

When we arrived on Greenholme House at 7:00am the television was on in the lounge but the sound was turned down so no one could hear it, it stayed like this until 11:15am. Apart from breakfast there was very little interaction with staff.

In one person's care plan we saw recorded, 'Will need support to access garden. Support to keep him occupied during the day with activities organised by the co-ordinator.' On the 8 August 2017 we saw this person was not involved in any activity. The last activity recorded in their care plan was on 6 July 2017 when they had gone for a walk around the garden. In another person's care plan, we saw they liked music based activities and the last record of this happening was on 12 June 2017. This showed care was not always delivered in line with people's assessed needs.

We saw from the activity plan on display, the activity for the morning of 8 August 2017 was 'Choir in the lounge.' We saw this consisted on Greenholme House of the activities co-ordinator going through a song book with one person who used the service and singing with them for a short period of time. During this time the television was on. None of the other people who used the service were involved.

We spoke with a visiting GP on 31/08/2017 in Greenholme House. The GP stated that "There is a lack of

activities for people (who use the service)" and they commented that the best engagement observed is "When people dressed up to go to Holy Communion." The GP further said people looked happy then and these included some of those who used the service whom they had never seen look happy before.

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

We spoke with the activities co-ordinator who told us they worked four days a week from 9:00am to 5:00pm and said they provided activities across both houses as there was a current vacancy for another co-ordinator for 20 hours per week. They said usually they worked on weekdays but would change their shifts around if there was something special happening at a weekend.

One person said, "In the past there were two people (leading activities) but now it's down to one." They continued, "Maybe one (another activity coordinator) will come, but we are not told. Activity is not really good; there are too many (residents) to cover. One person is not enough. It's very difficult because residents are at different stages of mind and body, but a lot more could be offered."

On the day one of the inspection we didn't notice any activities taking place until mid-afternoon when four people were sat around a table in the lounge doing different things such as colouring.

The service had built up links with local primary schools and the Church. Once a month a 'Cuppa, Cake and Company 'event was held in the local parish rooms and once a month the same event was held at Burley Hall. This gives people the opportunity to mix with people in the local community and make new friendships.

We observed a handover on the first day of our inspection. We saw this was informative and included details shared about each person, how they slept and whether there were any matters to be particularly aware of. We also saw communications sheets which gave key information about people's needs; such as if there were any appointments, visiting professionals, referrals required or concerns.

We looked at daily notes that recorded the care and support delivered to people. The care records we looked at contained some information about people's likes and preferences for care and support. This included foods they liked to eat, clothes they liked to wear and sleeping arrangements.

We looked at the care records for 14 people and saw in most cases sufficient information was available to staff about people's needs. Some care records contained a good level of person centred information and others required further personalisation to reflect people's personal preferences. We recommend that the service review all care records to ensure information was consistent.

We saw that although care plans were reviewed, these were not always thoroughly completed. For example, some reviews did not evidence how people and their families or other representatives had/or not been involved in the process. We saw the reviews did not always contain details of any changes to people's care and support needs. One relative was asked if they had been involved in any care planning reviews with his relative who was chronically ill and who has been in the home for a long time; they said, "Not for ages. They used to do it fairly regularly."

In the PIR the provider told us, 'A robust complaints policy is in place, and all complaints are answered within 21 days. Each complaint is thoroughly investigated and the complainant is provided with a written

outcome which may include apologies where there are failures or learning's by the Home'.

The provider had a complaints procedure which clearly outlined how concerns would be managed. It was easily available to people who lived and visited the home. We looked at two written complaints received this year and found they had been investigated appropriately. However, it is clear that not all complaints to the manager made by staff, persons and their relatives had been addressed.

People who used the service, relatives and staff spoken with told us they felt any concerns highlighted were not always taken seriously by the management team because action was not taken to address them. For example, one person said, "The buzzer response times are sometimes too long. It's not acceptable, however not much has changed. Depending on residents' needs, staff can be stretched. I find it frustrating." The issue around the buzzer was discussed with the manager who was unsure about the response times and the regional director was spoken to about this. Another comment included: "I have had to complain to the manager about the lack of staff and other staffing issues and nothing changed." When spoken to about the above, the manager stated that they ensured sufficient staff were on duty at all times to adequately meet people's needs although we found evidence that this was not the case.

Inadequate

Is the service well-led?

Our findings

At the last inspection we found there were not always sufficient staff on duty or deployed in the right areas of the home to keep people safe. For example, we found there were poor staffing levels on Greenholme house between 7.20am and 8.20am. This meant people sitting in the lounge during this period were left unsupervised in a room with no interaction, stimulation or access to drinks. This led to some people exhibiting behavioural problems.
On this inspection we found similar situations still existed which clearly showed the provider had not taken action to address this matter.

In the PIR the provider told us, 'Staff morale was heavily criticised at the last CQC report in January 2017. A lot of work has gone into making sure sufficient staff levels are maintained to deliver the care needed, and that people feel more genuinely engaged and driven to do a better job.'

We found at this inspection staff morale was still low and staffing levels had not improved. One example of this is when we looked at the records of post medication rounds reviews for June 2017 and found people had received their night medication between 18:15pm and 19.00pm on the 06/06/2017. This showed us people were not receiving their medication at the prescribed time. We brought this to the attention of the manager who told us they did not have enough nurses available for that night shift so people were given their medication early. Unlike the information provided in the PIR, this example indicated that sufficient staff levels are not always maintained to deliver the care needed.

At the time of inspection there was no registered manager in post. The organisation had recruited a new manager who took up post in January 2017 and was going through the Care Quality Commission registration process.

We received negative feedback from staff working at Burley Hall. Some staff told us, "The manager has no experience in care and doesn't understand what care is all about." "We are blamed for things which is not in our control, for example levels of staffing." Staff told us they did not feel supported by management. When they raised concerns, they were not taken seriously and nothing was done to address them.

Staff were very keen to talk with inspectors about staffing levels in the home. They reported staff were tired and morale was low because there was not enough staff. Two care workers told us the way the rotas were arranged meant they were working three 12 hour shifts in a row and then only getting one day off. One care worker told us they had raised this with the manager but no changes to the rota had been made. Staffing issues were also raised at the last inspection.

One member of staff told us when they had worked nights they had seen night staff sleeping and had reported this to the manager and had given them the names. They told us no action was taken. We discussed this with the manager who told us this was never reported to them as if it had, then action would have been taken.

Following our inspection visits, the regional director sent us an email to tell us the night staffing on Greenholme House had been increased from two to three care workers each night. They also told us they were reviewing day staffing levels and deployment of staff on both units. In relation to housekeeping cover at weekends they told us, "We have an additional housekeeper during the week as the activity, in comparison to the weekend, is increased over these days. We complete all ordering and receipting of stock during the week. In addition, we focus all deep cleaning outside of the weekend. We will carry out spot checks to identify any issues over a weekend. We have spoken to the weekend housekeepers and not identified any concerns." This is despite the fact that Burley Hall has 51 bedrooms, communal areas, toilets, bathrooms and shower rooms.

Although there were quality monitoring systems in place they had not been effective in achieving the required improvements in the service. They hadn't identified issues of incidents regarding safeguarding which were not always reported to relevant services. The manager was not notifying CQC about occurrences as they are required to do. We raised concerns about staffing at the previous inspection and this had not been acted on. Action required in care plans was not always followed through and issues around medication were not identified and addressed. We concluded people continued to experience a service which fell below the required standard for a good service.

There were two repeated regulated breaches and seven new regulated breaches identified. We concluded the provider remained in breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw relative/resident meetings had been taking place. We looked at meeting minutes for the last meeting in June 2017 and discussions included health and safety, activities for people and menus. One person we spoke with had attended the meeting and also completed a satisfaction survey. They told us they were able to express their feelings.

The home used survey questionnaires to seek people's views and opinions on the care and support they received. The 2016 resident/family survey showed that most people were very happy with the service. Where negative comments had been received, the survey showed the action taken to address these. This showed people's comments and suggestions were valued and used to improve the service.

We saw that staff meetings were held on a regular basis which management felt gave staff the opportunity to contribute to the running of the home. We saw the meeting minutes and the agenda included staff issues, infection control and training. In reality, many staff members stated that issues pertaining to staffing levels and rotas could not be openly discussed at these meetings as they felt little change had occurred when they had raised such matters in a less formal setting with the manager.