Maria Mallaband Limited

Batley Hall Nursing and Residential Home

Inspection report

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Date of inspection visit:
12 April 2018
19 April 2018

Date of publication:
04 July 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We inspected Batley Hall Nursing and Residential Home (known to people, their relatives and staff as Batley Hall) on 12 and 19 April 2018. Both days of the inspection were unannounced which meant the home did not know we were coming.

Batley Hall is registered to provide nursing and personal care for up to 51 older people, some of whom live with dementia. On day one of our inspection there were 37 people living at the home and on day two this number was 36. The home has three floors accessed by passenger lifts. Each floor has communal bathrooms and toilets, and there are shared lounge and dining areas on the ground floor. Outside there is a garden with seating areas.

Batley Hall is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The home did not have a registered manager. 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.

The home had a manager who formally left Batley Hall at the beginning of the same week we carried out our inspection. The senior operations manager had assumed day-to-day control of the service in their place.

People told us they felt safe living at Batley Hall and their relatives also felt assured their family member was safe. Staff had received safeguarding training and knew how to identify and report suspected abuse. We saw some complaints contained allegations of people's care needs being neglected. These allegations had not been reported to the Care Quality Commission. We dealt with this outside the inspection process.

Care plans lacked evidence of personal history and they were found to be inconsistent in the detail recorded. The senior operations manager was taking steps to improve end of life care through training and better recording. The registered provider was operating within the principles of the Mental Capacity Act (2005) and applications to lawfully deprive people of their liberty (DoLS) had been submitted to the local authority.

Since our last inspection, staff were seen to be significantly more aware of the need to provide care which protected people's privacy and dignity. The registered provider had ensured this was an area of focus through its training programme as this was a breach at the last inspection.

Training completion levels were seen to be high. Some staff supervision was taking place, although appraisals were not up-to-date. Staff felt they could approach the senior operations manager who was

approachable and very supportive.

The registered provider's monthly quality reports provided effective oversight of service delivery. We found concerns which we had identified during this inspection had already been highlighted and steps were subsequently taken to strengthen the management of the home.

Accidents and incidents remained a concern as there was a lack of evidence to demonstrate action had been taken to lower the risk of future occurrences. However, since our last inspection the registered provider had put in place more assistive technology to reduce the risk of falls.

We saw a number of examples where the senior operations manager had acted to learn lessons. A number of new initiatives had been put in place and we saw these were effective in identifying and meeting the needs of 'residents at risk'. These new systems need time to become embedded and we will look at this again at our next inspection.

Staffing levels were seen to be sufficient to meet people's care needs. However, we looked at the call bell response times for two days which showed people experienced waiting times outside the accepted range identified in the registered provider's own policy. We discussed this with the senior operations manager who told us they would look at this..

People were satisfied with the activities provision which the senior operations manager planned to strengthen following our inspection.

In response to our concerns about the breakfast experience, the senior operations manager took action to make this more personalised and feedback on the second day of our inspection showed this had improved. People were complimentary about the food, although records relating to dietary requirements and food and fluid charts required improvement.

People were supported to receive access to healthcare which we saw demonstrated through care records and from our conversations with people and their relatives.

Recruitment processes were found to be safe. The assessment of risk and management of medicines required improvement. A controlled drug error occurred on the first day of our inspection and some topical creams were evidently not being applied.

Fire safety and the maintenance of the building was appropriately managed. The premises were clean and an infection control lead had just been appointed.

Feedback was actively sought to engage people, relatives and staff in the running of the home. The culture within the service had improved since the last inspection, notably through the involvement of the senior operations manager who was approachable and well-liked by people, relatives and staff.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People said they felt safe. Moving and handling practices were suitably carried out. Examples of lessons learned were demonstrated.

The management and administration of medicines was not sufficiently robust. Some risks to people had not been identified and acted on.

Recruitment practices were found to be safe. There were sufficient numbers of staff to meet people's care needs.

Is the service effective?

Requires Improvement

The service was not always effective.

The frequency of supervision and appraisal required improvement. People received access to healthcare services.

People were complimentary about the food. The recording of people's dietary requirements needed improvement.

The service was working within the principles of the Mental Capacity Act (2005) and people had their liberty lawfully restricted.

Is the service caring?

Good

The service was caring

Staff had received training in privacy and dignity and improved interactions with people were observed.

Steps were being taken to involve relatives in care plan reviews. Concerns about confidentiality were acted on appropriately.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not provide staff with consistent and accurate information about care needs. Action was being taken to improve end of life care planning.

People knew how to complain if they were dissatisfied. Complaints were missing details of how they were concluded.

People were satisfied with the entertainment provided to avoid social isolation.

Is the service well-led?

Requires Improvement

Some notifications had not been submitted to the Care Quality Commission. Preventative action to lower risks in response to accidents and incidents was lacking.

The registered provider's monthly quality checks had identified concerns we saw at this inspection. Audits carried out by the outgoing manager were not sufficiently robust.

Examples of positive engagement with people, relatives and staff were seen. Other new initiatives needed to become embedded practice.

Batley Hall Nursing and Residential 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 12 and 19 April 2018; both days were unannounced. The inspection team consisted of two adult social care inspectors and an inspection assistant on the first day of inspection and two adult social care inspectors on the second day of inspection.

We did not ask the registered provider to complete a Provider Information Return prior to this inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

To prepare for the inspection we reviewed the information we held about the service and requested feedback from other stakeholders. These included Healthwatch Kirklees, the local authority safeguarding team, the local authority infection prevention and control team, and the Clinical Commissioning Group. We spoke with one visiting healthcare professional during the inspection.

During this inspection we spoke with four people who lived at the home and four relatives to obtain their views of the support provided. We spoke with the senior operations manager, the regional director, the quality and compliance manager, the administrator and 10 other members of staff.

We spent time observing care in the communal lounge and dining areas to help us understand the experience of people using the service who could not express their views to us.

We reviewed a range of records which included four people's care files. We also inspected three staff

members' recruitment and supervision documents, staff training records, nine people's electronic medicines administration records, accident and incident records, and various other documentation related to the running of the service.

Requires Improvement

Is the service safe?

Our findings

People and relatives we spoke with told us they felt safe at this home. One person told us, "They look after me and make sure I don't fall." Another person we asked whether they felt safe said, "Absolutely." A third person said, "Yes, there's always somebody there to watch out for you." Staff training records showed staff had received up-to-date safeguarding training. Staff we spoke with were able to describe abuse and knew how to report this. One member of staff said, "I'd whistleblow. I'd report it." 'Whistleblowing' is when a worker reports suspected wrongdoing at work.

People told us they were happy with the support they received from staff with their medicines. One person said, "I take them when they give them to me." Relatives also reported no concerns with the management of their family members' medicines.

At the last inspection in July 2017 we identified a breach of Regulation 12 relating to safe care and treatment as records for people who needed help to reposition in bed or when seated in a chair to reduce their risk of pressure ulcers did not evidence this support had been provided. At this inspection we checked the records of three people who needed help to move and found two of the three people had records to evidence they were supported to change position as per their skin integrity care plans, but one person did not. This person had no records in place to show staff helped them to move regularly. We raised this issue with the senior operations manager; they confirmed the person without repositioning charts did not have a pressure ulcer at the time of our inspection. The senior operations manager was aware further improvement to paper records kept in people's rooms were required and said they would ensure the correct repositioning charts were put in place for this person immediately.

On both mornings of our inspection we found a cabinet in the blue lounge which was used to store thickening powder was unlocked as the key had been left in the lock. This meant there was a risk to people as these are prescribed items which can cause choking. We saw this issue had been raised in consecutive monthly quality reports carried out by the registered provider during 2018.

On the second day of this inspection we observed a member of domestic staff supporting a person nursed in bed to eat their lunch. The domestic worker told us they had not received training on supporting people to eat; this concerned us as the person was at risk of choking and needed modified food and fluids. The senior operations manager told us they would investigate our concern.

On the first day of our inspection we arrived early and spoke with the staff member in charge of the night shift. We asked them how many people were living in the home and they told us this was 43. We spoke with the senior operations manager later in the day who confirmed this number was 37. We discussed the importance of staff knowing how many people were living in the building with the senior operations manager who agreed staff needed to know this for fire safety purposes. On day two of our inspection, the same staff member we spoke with on day one provided an accurate figure for the number of people living in the home.

We saw a communal toilet on the first floor had a broken toilet seat which staff had not identified. We discussed this with staff who told us all rooms in this area were en suite, although access to this room was still possible as it was unlocked. On day two we saw the toilet seat had been securely fitted.

We concluded these issues meant the registered provider was still in breach of regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 as these risks had either not been identified and/or acted on.

As part of this inspection we observed members of staff administering medicines. A nurse administered medicines to people receiving nursing care and a senior care worker administered medicines to people receiving residential care. The home used an electronic medicines system. We saw staff checked people's electronic medicine administration record (eMAR) before administering medicines and recorded the person had taken their medicines on the eMAR system afterwards. Staff members administered medicines from trolleys which they locked when leaving them unattended.

We observed staff administered medicines to people in a caring and person-centred way, and made more than one attempt to administer medicines to people living with dementia who either refused or were asleep. We saw the eMAR system ensured people's medicines were not missed if they could not be administered at the first attempt. People were asked if they needed medicines prescribed 'when required', for example for pain, and care plans were available to inform staff as to how people took these medicines.

Medicines were stored in a dedicated room which contained a fridge; both the room and fridge were monitored to ensure medicines were stored at the correct temperature. We checked the stock of medicines, including those of controlled drugs, and found some issues. Controlled drugs are those covered by misuse of medicines legislation, and include medicines such as strong painkillers. Stocks of two out of five medicines we checked did not reconcile with recorded amounts. In addition, when we checked stocks of three controlled drugs we found the amount of two of the three drugs was not correct; this was because one person's slow release painkilling patch had been applied to a different person who used the same medicine. Fortunately, the patches contained exactly the same medicine in the same dosage, but this was still concerning as two members of staff had checked the medicine prior to it being administered. The senior operations manager told us they would investigate the incident in order to learn lessons and prevent such errors in future.

Unlike oral medicines whose administration was recorded on the electronic system, the administration of people's prescribed topical creams such as moisturisers and barrier creams were recorded on paper records by care workers. When we sampled people's paper medicine administration records for their topical creams we found some gaps; however, upon checking people's rooms we found part-used creams which suggested the issue was a lack of robust recording rather than a failure to administer people's creams. During the inspection we attended a 'residents at risk' meeting chaired by the senior operations manager; they reported an audit of room records had identified concerns around record-keeping and in response they had already arranged a staff meeting specifically about record-keeping the week following our inspection.

We found two people had not received topical creams as prescribed because they had not been entered properly on the eMAR system. We found unopened or barely used tubes of the creams in stock and there were no records of the creams ever being applied despite their being dispensed weeks before this inspection. Because they were added incorrectly to the eMAR system staff had not been prompted to apply them. This meant people did not always receive their medicines as prescribed.

We concluded issues with medicines management and administration were a breach of Regulation 12(1)

and (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 as some topical creams were not being applied and concerns about the management of controlled drugs.

A fire risk assessment had completed in December 2017. Personal emergency evacuation plans had been updated at the beginning of April 2018. We saw records of fire drills having taken place on a monthly basis since December 2017, one of which included a drill when night staff were present. This helped to ensure all staff knew what to do in the event of a fire.

Certificates we looked at showed gas safety and electrical wiring had been checked within relevant timescales. We also found lifting equipment had been thoroughly examined within the six months prior to our inspection. We saw relevant checks had been carried out in relation to other aspects of maintenance.

During the inspection we attended a 'residents at risk' meeting chaired by the senior operations manager and attended by representatives of the nursing, care, domestic, maintenance and kitchen staff. At this meeting the senior operations manager explained the appointment of champions amongst the staff for skin integrity, falls prevention and infection control. They explained champions would receive additional training and act as a focal point for contact with external healthcare professionals. An outbreak of diarrhoea and vomiting which was resolved shortly before this inspection was also discussed, along with any lessons learned from how it had been managed. We noted the senior operations manager encouraged staff to participate in the meeting and share their ideas as to how the home could improve. This meant measures were in place to learn lessons at the home, and management were keen to ensure ownership of the need to learn and improve was shared across the staff team.

At the last inspection we saw people were not always supported safely by staff to transfer and mobilise, and people's care plans did not always contain sufficient detail about how to support people to move safely. At this inspection all of the moving and handling of people we observed was safe and respectful. Care plans had improved, in that they now contained the type of equipment staff should use and the sling size, if necessary. This meant moving and handling procedures had improved since the last inspection.

At our last two inspections, we found pressure mattress settings were not clearly recorded which meant people were at risk of developing pressure wounds. At this inspection we found staff had received training in this area and the senior operations manager had sampled these to check they were correctly set.

The first day of this inspection was warm and sunny. Staff asked people if they wanted to sit outside on a terrace that was not shaded from direct sun and a few people said yes. We saw the staff encouraged people sitting outside to wear hats, and also supplied them with sun screen. This meant the service ensured people were protected from sunburn as they enjoyed the nice weather.

On the first day of our inspection we were made aware of an allegation of abuse which had been responded to appropriately. A notification had been submitted to the CQC and the local safeguarding authority. Measures were put in place to protect the person from harm.

We looked at the safeguarding log and found records which showed investigations had taken place. These incidents had been reported to the CQC.

We asked people and relatives whether they felt there were sufficient numbers of staff to meet their needs. People told us, "There's always somebody handy if I need them. I never wait long", "They're always coming to check on me and have time to talk. It's never that long a wait." One person felt the staff were stretched, although they didn't express concerns about this impacting on the care they received. The same person said

about night staff cover, "If I need them, there's somebody there." One relative told us, "I think that's been a bit of a problem since before Christmas, but they seem to be getting it sorted out. It's picking up now, yes." Staff we spoke with said there were sufficient numbers of staff providing everyone turned up for their shift.

We looked at staff rotas covering a four-week period and saw the home was routinely staffed at levels determined by a dependency tool and on occasions staffing numbers exceeded this.

People we spoke with told us staff responded to their call bells promptly. The senior operations manager told us a staff member was responsible for monitoring call bell response times and noted the average time for staff to respond was under three minutes. We looked at the call bell response times for 11 and 12 April 2018 and found examples where people had to wait between six and 12 minutes for staff to respond. The registered provider's policy for answering call bells dated October 2017 stated staff should respond within four minutes. We showed our findings to the senior operations manager to make them aware of this. They told us they would look at this immediately.

We asked a member of staff whether agency staff usually worked on night shifts and they told us, "Quite a lot of the time." At the time of our inspection vacancies existed for a deputy manager and three full-time nursing staff. We saw the registered provider's monthly quality reports showed the number of staff vacancies had reduced. The senior operations manager told us they wanted to reduce agency usage and plans were in place to fill one of the nursing vacancies.

Immediately before our inspection the home had experienced an infection control outbreak which they were clear of at the time of our inspection. We looked around the home and found it was clean and without malodour. The senior operations manager told us they had appointed a senior care worker to become the infection control lead for the home. They had role-specific training booked for May 2018.

We looked at the recruitment process followed for three members of staff and found this was safe. We saw evidence of application forms, detailed interview records which were scored and evidence of identity of the staff member having been checked. Background checks had been carried out through references and with the Disclosure and Barring Service (DBS). The DBS assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people.

The senior operations manager had looked into why some staff members who had started employment in the home had left shortly afterwards. They told us they had found new staff members had not always felt supported by the existing staff team. The senior operations manager had since appointed three staff members as 'people's champions' which they also referred to as 'Batley Buddies'. This role was intended to assist new members of staff coming into the home to ensure they were warmly welcomed and supported as they became used to working in the service. This demonstrated lessons were learned by mitigating against the risk of the same thing happening again.

Requires Improvement

Is the service effective?

Our findings

We checked to see if the service was compliant with the Mental Capacity Act 2005 (MCA). The 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 or 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.

People's electronic records contained capacity assessments and best interest decisions for various aspects of their care and treatment. For example, support with personal care, taking of photographs and support with mobility, including hoisting. During the inspection we observed staff provided people with choices, for example, what to eat, what activities to take part in, and where to sit in the lounge area. People were also asked for their consent by staff before support was provided. One person told us, "They always ask about when to go to bed. I get to decide", and a second said, "I get up early by choice", then added, "We do have choices with meals, and what I wear." One staff member said, "It's about giving people choices. You can't assume they can't make any decisions. We don't overpower people with choices as it can confuse them even more." This meant people were supported by staff to make their own decisions.

The registered provider showed us a tracker they used to record DoLS application and authorisations. This demonstrated applications to lawfully deprive people of their liberty had been submitted to the local authority.

People told us they enjoyed the food and drinks served at Batley Hall. One person, "I always send my compliments to the chef if I've enjoyed it", a second person told us, "I get a choice of meals. I have a cooked breakfast here", and a third person said, "It's brilliant. I never leave anything. I have three meals a day and they offer supper too. They do give you a choice."

At the last inspection in July 2017 most feedback about the food was positive, however, we did receive mixed feedback about whether the food was served hot. At this inspection we observed breakfast on the first day. We saw most people chose to have breakfast in their rooms. A trolley containing trays for each room was taken to each floor and a member of kitchen staff took the trays and served drinks from tea and coffee pots according to people's choice. We noted trays were already plated up with either cooked food items or cereals and toast which had already had margarine and marmalade applied. Staff told us people received the same breakfast choice every day, but could refuse it at the time it was served and ask for an alternative if they wanted to. We were concerned people may not want to bother staff by refusing food already prepared for them and ask for something else. We also noted it took more than half an hour to finish serving breakfast

on one floor, which meant items such as tea, porridge and toast were no longer hot. The main meal at lunchtime was served from a hot trolley.

We raised our concerns with the senior operations manager. They told us a meeting had been arranged with kitchen staff the same week. On the second day of this inspection we saw a new breakfast system was in place. People were served their choice of cereals and hot drinks from a trolley and asked if they wanted a cooked breakfast, porridge or toast; if they did, this was then made for them and served hot. One staff member told us, "People are choosing different things. It's working really well." This meant the registered provider took action to make improvements, but as this was a finding at the last inspection, action taken was not timely.

In the kitchen we found the correct checks were made on food and the equipment used to store it. The cook we spoke with was knowledgeable about different people's needs and preferences, for example, those who needed their food modified to lower their choking risk, or people with diabetes. There were no records of individuals' needs and therefore there was a reliance on staff knowledge; we were concerned about what would happen if an agency cook needed to be used. The senior operations manager told us they would ensure records of people's needs and preferences would be kept in the kitchen in the future. They also told us a dietician was coming to speak to staff about tips for promoting snacking for people at risk of weight loss, and to provide ideas about how to improve communication between kitchen and care staff around people's dietary needs. This meant the senior operations manager had sought advice from healthcare professionals in order to make improvements for people.

On day one of our inspection we observed the lunchtime experience and saw this was positive. Tables were well presented and people were asked where they wanted to sit in the dining area. People were given hand wipes before the meal started and offered a choice of hot and cold drinks. A choice of two meals was provided and people could ask for something not on the menu. The portion sizes were adequate and the food was hot and people were asked if they had enough. One person was being assisted to eat their meal by a member of staff. The staff member was very patient and waited until the person had finished chewing and had swallowed their food before offering more. The staff member provided reassurance throughout.

The home had been awarded a 'Healthy Choice Award' by Kirklees Council for being committed to good standards of food hygiene and healthy food options.

Records showed people who had lost weight received the right support and referrals were made to other health care professionals, as required. We found the quality of records kept of people's food intake was mixed, as some records did not state how much food a person was given to eat and only recorded how much they had eaten as 'all' or 'half.' This meant the records of people's food intake were not always meaningful.

We asked people if they thought staff were sufficiently skilled in their roles. One person said, "Yes, I think so. I don't have trouble with anybody."

The senior operations manager told us they had recently overseen delivery of a comprehensive induction programme for ten new members of staff. The registered provider's monthly quality reports for 2018 showed training gaps had been addressed and by the time of our inspection, completion levels were found to be high. The senior operations manager had arranged for specific training sessions, such as dignity, nutrition and sepsis to be provided. In addition, all nursing and senior care workers had received a pack about urine testing along with NHS guidance. Up to date policies and procedures were in place, such as those in relation to safeguarding, health and safety, medicines and infection prevention and control. Having up to date

policies and procedures in place helps to ensure current, up to date, guidelines are followed.

We looked at whether staff received regular supervision and appraisal and found this was not happening. Three staff records showed the most recent appraisals had been carried out in October 2016, December 2016 and 2014 (no month was recorded). However, we saw the same staff members had received some recent supervision sessions which meant they had a formal route to discussing concerns and their own personal development. One staff member said, "I haven't had one (supervision) for a couple of months." They told us this stopped when the outgoing manager was in post. However, the same member of staff commented, "I could talk about my concerns and how I felt." We concluded this was an area of improvement for the registered provider and recommend they ensure staff receive more regular supervision and appraisals.

We asked people about the support they received from staff to access healthcare services. One person said, "They'll get the GP if I need them." A relative told us access to healthcare was provided in a timely way. They said, "They ring if anything happens or the doctor comes." We spoke with a visiting health professional who did not have any concerns about the care staff provided. Care records we looked at showed a range of healthcare professionals were involved in people's care.

The senior operations manager told us the home had been split into different sections to make it easier to navigate. They told us signage had been ordered to direct people to areas including 'The Hall' and 'The Gables'.

We looked at how information was provided and shared with people. The Accessible Information Standard came into force in 2016 with the aim of ensuring people with disabilities, impairments or sensory loss get information they can understand and any communication support they need. The senior operations manager told us the menu was presented in a pictorial format. Staff were working with the family of one person to obtain information on the most appropriate language format to use. The relative of this person told us they had been asked by the home to put together a list of words for staff to help them communicate and we saw these had been made available for staff.

Good

Is the service caring?

Our findings

We spoke with people and their relatives and asked whether they were treated with kindness, respect and compassion. One person told us, "I class them all (staff) as my friends", and they added there was "Lots of banter." Other comments people made about staff included, "Nothing is too much trouble for them", "Everything's all right", "I get on with most of the staff" and "The lady who brings the clothes is very chatty." One relative told us, "The staff are kind. They're superb." Another relative said, "The staff are lovely. They're excellent." A third relative said, "I find some of them are incredibly friendly and understanding."

On both mornings of our inspection we found some room doors were open whilst people were asleep. We looked at this and found care records showed whether it was a person's preference to have their room door open or closed.

At our last inspection we saw staff did not respect people's privacy and dignity as they openly made comments which showed little respect for people living in the home. At this inspection we saw the interactions between staff and people were considerably more respectful and dignified. The senior operations manager told us, "All staff have been trained in dignity training." They added staff were using a workbook to reinforce their learning.

One person said, "If they take my top off they always cover me up." We spoke with one relative who said, "They ask us to wait outside and close the door and curtains. They're very good that way." Another person said, "They put me at ease during personal care." A third person told us, "Everybody's respectful. They do exactly what you want them to do, when I want it."

Staff we spoke with were able to describe steps they took to ensure people's privacy and dignity was maintained. One staff member said, "We make sure the doors are shut and use the privacy curtain for hoisting. We don't discuss their information (in front of others) and log out (of the computers) correctly."

One person told us they were encouraged to maintain their independence and shared an example of staff handing them a flannel so they could continue to wash themselves as much as possible. They said, "They try to encourage me to do things for myself." Another person commented, "I do what I can, they do the rest." People we spoke with confirmed they were able to have a bath and shower when they wanted. One person said, "They ask me on a morning if I want one." Another person told us, "I've only to ask. When they've done, I feel really clean." On day two of our inspection, we saw one person being enabled to fold napkins which meant they were able to take part in preparations for the dinner service.

We saw examples of staff walking alongside people they were supporting and ensuring they walked at the same pace the person was able to travel. Interactions between people and staff who cared for them had improved at this inspection. We saw a staff member responded when a person spilled a cold drink over themselves. The staff member discreetly assisted the person and supported them to have a change of clothes. Another staff member responded to one person expressing tiredness by asking them if they wanted to be helped to go for a lie down. Staff were familiar with people and their preferred care routines and

referred to people by their name. On the second day of our inspection, a staff member used the privacy screen to protect a person who was sat in direct sunlight in the lounge. This helped to avoid them becoming uncomfortable and over-heated.

Care workers we spoke with could describe good practice when supporting people who live with dementia. One care worker said, "It's time, patience and understanding", and a second told us, "You've got to get onto their level, and how they communicate." During the inspection we observed a care worker supporting a person who became distressed and was asking for their mother. The care worker provided reassurance and used distraction techniques to alleviate the person's distress and encouraged them to have their breakfast instead. We saw the person responded well to the care worker and experienced a positive interaction. Other interactions we observed during this inspection between care workers and people living with dementia were patient and understanding, and demonstrated the person-centred aspect of support received by people living with dementia.

On the first morning of our inspection we arrived early and found confidential information had been left out by night staff. For example, one person's behaviour chart and another person's visual observation chart as well as food and fluid charts had been left outside each person's room. A member of staff told us this had been custom and practice for several months. We discussed this with the senior operations manager and on day two of our inspection we saw these records were securely stored. The senior operations manager had asked staff to sign a commitment to ensuring good standards of information security, confidentiality and privacy.

People and relatives we spoke with evidently had limited involvement in their care planning, although they added they were not concerned about this. We asked one relative whether they knew they could ask for the care plan to be reviewed. They said, "If I asked, they'd do it, but I'm happy with what they do." The senior operations manager told us invitations to care plan reviews had been sent out by the home manager, although the senior operations manager found the time between reviews needed to be shortened to complete these sooner. An updated letter inviting relatives to their family member's review was due to be sent out following our inspection. Relatives we spoke with confirmed they had been invited to care review meetings.

The senior operations manager told us people's equality, diversity and human rights were maintained through staff training and as part of pre-assessments, Care plans we looked at showed people's religious needs were recorded and we saw people were supported to maintain their religious beliefs. Pictorial books had been acquired to support people who had specific communications needs. This meant these needs were being considered at the time of our inspection.

Requires Improvement

Is the service responsive?

Our findings

We looked at four people's care plans and found in places they were contradictory and/or they lacked detail. Care plans were stored on an electronic system. We saw each care plan was divided into separate sections which were easy to navigate. One person's 'personal care, oral and foot hygiene' care plan stated the person 'does not require any eye care'. This contradicted their communication care plan which stated they required regular eye tests. The same person's 'care and infection' plan stated '[Name of person] does not have an infection and has not been in touch with anyone who does'. In the same entry it was recorded the GP had prescribed antibiotics to treat an infection.

Another person's nutrition care plan stated '[Name of person] has a healthy appetite and diet and drinks well, they have recently gained weight. This contradicted the person's weight chart which showed they had been losing weight since October 2017. A staff member told us a dietician had been contacted, although the person had refused their involvement. A third person's care plan contained contradictory information about their religious beliefs. We had identified the same issue at our last inspection. The same person's communication care plan stated they struggled to communicate their needs, although we were able to talk with this person during the inspection and they were able to express their wishes verbally.

Care records we looked at lacked information about people's life history and their activity records were sparse.

We concluded this was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as care records did not provide staff with consistently accurate details of people's care needs.

Care plans did not contain people's end of life wishes which the senior operations manager had identified. They told us they were looking at end of life training for staff which would help them provide more effective care for people requiring end of life care.

Staff could describe to us what was important when supporting people nearing the end of their lives. One care worker said, "You give more TLC (tender loving care), more comfort. Sit and hold people's hands", and a second care worker told us, "It's making sure they're as comfortable as possible – constant checks. Trying to encourage fluids and mouth hygiene."

Medicines were in stock for people receiving end of life care, or who were thought to be approaching the end of their lives. So-called 'anticipatory drugs' are those some people need to remain comfortable in the final few days of life; it is good practice for services to have such medicines in stock ready for when they are needed.

We looked at whether people knew how to make a complaint and how these were managed. One person told us, "I've got nothing to complain about at all. I'd see the manager if I wanted to." Other people we spoke with felt confident they could raise a concern or make a complaint.

We looked at records of complaints and found there were gaps in the recording which meant the registered provider was unable to demonstrate these had been dealt with appropriately. For example, a relative had made a complaint in January 2018 which alleged a person's care needs had been neglected. The front sheet used to record 'actions' had nothing noted against this. The outgoing home manager had identified the duty of candour applied, but it was not clear what they had done about this. In February 2018, a complaint was made concerning a person who had used their call bell. A member of staff allegedly responded by saying they were too busy to provide assistance. There was no action to identify how this was dealt with.

When we looked at the complaints records we saw a number of incidents which had been dealt with by the outgoing home manager and prior to this the last registered manager which identified suspected abuse. These incidents had not been reported to the CQC. The registered provider's monthly quality reports dated January, February and March 2018 showed concerns had been identified about the way complaints were being recorded.

We concluded this was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as records did not demonstrate how complaints had been handled.

People told us activities were provided at the home and they had enough to do. We noted a large proportion of people stayed in their rooms for most of the day. Those we spoke with confirmed this was their choice and they were informed of activities and asked if they wanted to join in. One person said of activities provision, "We play bingo and they have a sing-a-long." On the second day of the inspection a singer entertained people in the main lounge area. One person who had come to see the singer told us, "He was lovely. I prefer to stay in my room otherwise", and a second person said they listened to entertainers from their room as that was where they liked to be. The relative of another person who liked to stay in their room told us staff encouraged the person to come to the lounge area and join in with activities; they said, "Believe me, they've tried!" The person said they preferred their own company instead.

Records showed people either took part in activities or were asked to take part in activities on most days of the week. People who stayed in their rooms were visited for one-to-one chats. One popular new addition to the home just before this inspection was 'The Batley Arms', a small bar area where alcoholic drinks were available. We spoke with one person out enjoying the sunshine with an alcoholic drink on the first day of this inspection. They told us, "We have a little bar. My friends enjoy it too." The March 2018 staff meeting minutes stated 'The pub/coffee lounge - There is a lot of work being done. We must try to encourage people where possible to start using this area'.

The senior operations manager said, "Formal activities have not been as positive as they were." Two activities coordinators had started at the home shortly before this inspection, as the last one had left in February 2018. The senior operations manager said they would be given training for this role and support would come from an activities coordinator based at another home operated by the registered provider.

The regional director and senior operations manager told us people were supported through the use of assistive technology such as door sensors, sensor mats and electronic medicine administration records.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in July 2017, we rated this key question as 'Inadequate' and a breach of Regulation 17 relating to good governance was identified. Part of the breach was a failure of the service's audit systems to identify areas of concern we identified at inspection, for example safeguarding, health and safety, and infection control. At this inspection we found governance systems had already identified some of the concerns we found at this inspection. The registered provider had taken action to strengthen the management team in response to the concerns they had identified.

On day one of our inspection the senior operations manager told us the home manager, who had been in post since December 2017, had formally departed the service days before our inspection. They told us steps had been taken to strengthen the management of the home and the regional director said the senior operations manager had been involved at Batley Hall Nursing and Residential home 'on and off' for six months. We were told the senior operations manager would manage the home on a daily basis until a home manager was appointed. Following our inspection, the senior operations manager informed us a peripatetic manager would be working in the home from May 2018. In addition, a new home manager had been appointed who they would work with to ensure a robust handover. At the time of our inspection the home did not have a deputy manager.

We looked at records of accidents and incidents which had occurred during 2018 and saw a monthly total of accidents and incidents which was broken down into categories of 'bumps and bruises', 'cuts', 'skin tears' and 'no injury'. Four-hour blocks of time were used to show the time of day the accident/incident took place. Of the 25 accidents and incidents from January to March 2018, we saw 17 had resulted in no injury, two were bumps and bruises and six related to cuts and skin tears. Each accident form contained a record of what had happened which showed staff had taken action following the event.

We looked at the overview of accidents and incidents and saw this required improvement as records did not demonstrate what follow up action had been taken to lower risks to people. We looked at the 'Record of Visit on Behalf of Registered Provider' dated January, February and March 2018 which looked at activity during the prior month. We saw the accidents and incidents for December 2017 had not been followed up by the outgoing manager. The outgoing manager had delegated this to the deputy manager who had not done this. It was noted by the quality inspector who completed this report, 'No falls pathways had been completed for residents who had fallen. Accidents have not been effectively monitored'. The following month, six events had not been reviewed and these were subsequently followed up. In March 2018, it was stated 'Out of 12 recorded accidents in February only 5 have been reviewed and followed up by the manager'. We saw the accidents and incidents analysis for February 2018 stated both risk assessments and care plans had not been updated following accidents and incidents. This meant there had been an ongoing failure to ensure all accidents and incidents had been thoroughly analysed to demonstrate learning outcomes which could be used to lower risks to people.

At the beginning of the week we inspected this service, the senior operations manager named a staff member responsible for accidents and incidents. A member of staff we spoke with told us the registered

provider had acquired assistive technology and other equipment since our last inspection to support people's moving and handling needs and to reduce risks to people living in this home. We saw evidence of this through the use of different sensors to identify when people who needed assistance to walk were moving and crash mats to prevent harm where people were at risk of falling out of bed.

We found no medicines audits had been completed for March 2018, and the audit for February 2018 had been completed by a member of nursing staff who was involved in medicines management, rather than a manager. This audit was not completed fully, with gaps in areas such as topical creams. Records showed a thorough audit of medicines had been completed by a compliance inspector for the registered provider in January 2018; a detailed action plan was attached, but no actions had been signed off as complete and the compliance inspector confirmed to us this was the case. As discussed earlier in this report, we identified a breach of the regulation relating to safe care and treatment in relation to medicines management at this inspection. This evidenced a lack of governance and oversight with respect to medicines management at Batley Hall.

We looked at the infection control audit dated January 2018 which scored 95.2% compliance and found the quality inspector for the registered provider had reviewed this in February 2018 and commented 'Audit does not reflect current state of home – needs to be recompleted more robustly'.

During our inspection we looked at records of complaints and found four instances where allegations of abuse had been made. We checked these against our databases and found they had not been reported to us. We showed these to the senior operations manager who agreed these were reportable events. In addition, we saw a Deprivation of Liberty Safeguard authorisation which the registered provider had not reported to us. We dealt with this outside the inspection process.

We concluded this was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as systems and processes were not operated effectively.

We saw an email from the senior operations manager to the outgoing home manager dated January 2018 which encouraged them or the deputy manager to attend the staff handover. The email stated 'We really need strong leadership from the beginning of the day to ensure direction'. At the time of our inspection, systems were in place to share information across the staff team if people's needs changed. We attended a 'handover' meeting between day and night staff where details about people and their needs were discussed with the staff coming on shift. This meeting included an emphasis on people the service deemed to be 'residents at risk.' These included people who had been prescribed antibiotics, were at risk of falls, or who were receiving end of life care. 'Flash meetings' were also held during the morning shift to discuss the 'resident of the day', whose care plans were to be reviewed and updated. This meant information about people's changing needs was shared across the staff team.

Also during the 'residents at risk' meeting the senior operations manager shared good practice around the prevention and identification of urinary tract infections (UTIs), and the signs and symptoms of sepsis. A discussion was held around when a GP should be called and antibiotics requested for potential UTIs. This balanced the need to reduce unnecessary antibiotic use with an awareness that people's risk of sepsis should not increase as a consequence. This meant good practice was shared with staff and used to promote people's health and wellbeing. The senior operations manager was seen praising staff and welcoming their feedback,

We found a number of new initiatives had been recently introduced by the senior operations manager. We will check these have become embedded at the next inspection.

Three members of staff had been appointed as care practitioners which meant they would wear a different uniform and would have greater responsibility for standards of care provided. The senior operations manager told us part of the care practitioners working week would be supernumerary which meant they would have time set aside specifically for this role. One relative told us they had found this change confusing and wasn't sure who they should approach about their relative's care.

We asked people, relatives and staff whether they felt the care home was well-led. One person told us, "It wasn't to begin with (last registered manager), and (outgoing home manager) didn't do anything. It's fantastic now. The girls seem to know what they're doing now." Another person said, "As far as I'm concerned it is." One relative said, "I think it's top notch. (Senior operations manager) is doing a good job. She's very nice, she's very approachable. The girls (staff) seem a lot happier." One staff member said, "I think (senior operations manager) is brilliant, I think she's so approachable. She said if there's anything worrying you please come and tell me." A second staff member commented, "The atmosphere is much better. It's really nice to be appreciated (by senior operations manager)." A third staff member said, "Morale is much better. They listen to feedback. We can say what we want, what we think."

The senior operations manager told us, "I think the culture in the home has improved." The senior operations manager told us several 'clinics' had taken place in the home which were run by the registered provider's human resources team to give staff an opportunity to speak confidentially about any concerns.

On the first day of our inspection the senior operations manager told us the last 'resident' and relatives meeting had been cancelled by the outgoing home manager and they had scheduled the next meeting for the following weekend. On the second day of our inspection, they told us no one had attended and they would reschedule this event. Monthly 'resident' and relative meetings had been scheduled for the remainder of the year. Prior to this two cheese and wine evenings had been held in November 2017 and January 2018. In February 2018, the regional director had organised a staff evening for the team to meet relatives. The senior operations manager told us this had been successful.

In October 2017, the registered provider asked people and their relatives to complete satisfaction surveys. We looked at the results of these and saw people living in the home were more satisfied than they were 12 months earlier, although relatives' satisfaction levels had reduced in the same period. The senior operations manager told us survey findings had not yet been discussed with people and their relatives, although they said they would raise this at the next 'resident' and relative meeting.

A staff survey sent out to all staff had been completed by two members of staff. One staff member told us the feedback was put on display in the staff room, although evidence of this could not be located during our inspection.

We looked at staff meeting records and saw the last meeting took place in March 2018. These covered privacy and dignity which was a concern at our previous inspection, recording use of topical creams, training completion rates, recording people's open/closed door preferences and the staff recognition scheme. The staff meeting before this took place in January 2018. We also saw evidence of meetings for heads of department. This demonstrated staff were supported through regular team meetings.

We looked at how the care home worked in partnership with other agencies and found they had had limited evidence of such links. We recommend the registered provider looks to develop these links.

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 9 HSCA RA Regulations 2014 Person-centred care Care records did not provide staff with consistently accurate details of people's care needs.

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 Some topical creams were not being applied and there were concerns about the safe management of controlled drugs. Specific risks to people had either not been identified and/or acted on.

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 and processes were not operated effectively as not all areas of concern we found at the last inspection had been acted on. Records did not demonstrate how complaints had been handled to ensure these were appropriately responded to and lessons were learned.