Flowertouch Limited

Carrgreen Nursing Home

Inspection report

Carr Green Lane
Rastrick
Brighouse
HD6 3LT
Tel: 01484 710626
Website:

Date of inspection visit: 28 January 2015
Date of publication: 14/04/2015

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?	**Inadequate**
Is the service well-led?	**Inadequate**

Overall summary

We inspected Carr Green Nursing Home on 28 January 2015 and the visit was an unannounced comprehensive inspection.

Our last inspection took place on 3 September 2014. At that time, we found breaches of legal requirements in five areas. These included; care and welfare, cleanliness and infection control, safety and suitability of premises, staffing and assessing and monitoring the quality of the service. We served warning notices for the breaches in relation to safety and suitability of premises and assessing and monitoring the quality of the service. In these notices we asked the provider to make improvements to the safety and suitability of the premises by 24 October 2014 and assessing and monitoring the quality of the service by 21 November 2014. The provider sent us an action plan telling us they would make improvements to ensure they no longer breached regulations in the other three areas.

Carr Green Nursing Home provides both personal and nursing care for up to 25 older people. The accommodation is all on one level and consists of a lounge, dining room and 25 single bedrooms. At the time

Summary of findings

of our visit there were 15 people using the service. The number of people using the service had reduced as following our last inspection placements were stopped by the organisations who commission and pay for the service.

The service has 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 and associated Regulations about how the service is run.

We found the provider had not taken appropriate action to ensure they met the requirements of the warning notices and to ensure they no longer breached regulations.

We found fire doors that were not closing properly or were being wedged open. This meant they would not be effective at holding smoke back in the event of a fire.

A current gas safety certificate and electrical installation certificate were not in place. This meant we could not assure ourselves the installations were safe.

The temperature of the building was variable with some areas being draughty and additional heaters were in some bedrooms to maintain a comfortable temperature. The hot water coming out of some of the bedroom taps was in excess of 60 degrees centigrade and posed a scalding risk.

We contacted West Yorkshire Fire Service and the Health and Safety Executive following our visit to report these concerns.

The medication system was not well managed and medicines were not being stored at the right temperatures. The medication policy was out of date and there were no protocols in place to make sure any 'as required' medication was given appropriately.

We saw induction training for new staff was completed in one day and this covered 10 or 11 topics. Staff had not received any practical moving and handling training in how to use hoists or other equipment safely.

We found the service was not meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS).

People told us the food was good and we saw people were offered a choice of meals at breakfast and lunchtime.

People told us they liked living in the home and staff were kind and caring. People also told us they enjoyed the activities on offer in the afternoons.

We found people's care records were not always up to date and did not reflect people's current care needs. They also lacked assessments of risks to some individuals and information about what action staff needed to take in order to reduce those risks.

We found the service was not well led. The lack of effective quality monitoring systems meant the provider was not identifying its own deficiencies and acting upon them. There were significant areas which were having a detrimental impact on the care and well-being of people using the service.

We found on-going breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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.

There were areas of the home that were not well maintained and were posing risks to people who lived there. Up to date gas and electrical safety certificates were not in place to show the installations were safe.

The medication system was not being managed properly. The medication policy was out of date and there were no protocols for staff to follow when giving as required medication.

Staff did not always follow safeguarding procedures and there were incidents that should have been reported to the local safeguarding authority that had not been.

Is the service effective?

Requires improvement 

The service was not always effective

We found the service was not meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS).

Not all of the staff had received all of the training they needed to care for people effectively.

People's nutritional needs were met and people told us they enjoyed the food.

Is the service caring?

Requires improvement 

The service was not always caring.

We saw individual care workers treated people with patience, care and kindness. People using the service and visitors told us they liked the staff and found them kind and helpful.

A visitor told us they were always made to feel welcome and found the staff friendly. However, we did find some practices which showed a lack of respect for people using the service.

Is the service responsive?

Inadequate 

The service was not responsive.

Care plans were not always up to date and did not always reflect people's current needs. The lack of effective care planning put people at risk of receiving unsafe care.

Staff were not able to deal effectively with people's behaviours that challenged the service.

A complaints procedure was in place but no complaints or concerns had been recorded.

Summary of findings

Is the service well-led?

The service was not well-led.

Although there were some systems in place to look at the quality of the service these were ineffective and had not identified many of the areas for improvement that were identified during our visit.

Inadequate

Carrgreen Nursing 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 28 January 2015 and was unannounced.

The inspection team consisted of three inspectors and an expert by experience in older people and older people living with dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service. This included speaking with the local authority contracts and safeguarding teams. Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This document was not returned to us.

On the day of our inspection we spoke with seven people who lived at Carr Green Nursing Home, one visitor, two nurses, four care workers, the activities coordinator, handyperson and cook and the registered manager.

We spent time observing care in the lounge and dining room and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us. We looked around the building including all occupied bedrooms, bathrooms and communal areas. We also spent time looking at records, which included five people's care records, three staff recruitment records and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

When we visited in September 2014 we were concerned people using the service were not being kept safe because of issues with the safety and suitability of the premises. We issued a warning notice which told the provider they must make improvements by 24 October 2014.

At the visit in September 2014 inspectors found issues with fire safety and referred their concerns to the West Yorkshire Fire Service. They visited and served an enforcement notice requiring the provider to make improvements by 13 March 2015.

On this visit we found appropriate improvements had not been made to ensure people's safety in the event of a fire. Some fire doors did not close securely into the frame. We also found the kitchen door was held open with a chair and a bedroom door was held open with a wedge. Both of these doors were fitted with 'door guards.' These are devices that allow doors to be held open but close automatically when the fire alarm sounds. The registered manager told us these devices were not working because they needed new batteries and they were waiting for these to be supplied by the provider.

We saw some of the bedroom doors had been painted and paint had been left on the special fire seal strips in the doors. This meant the seals would not be effective in the event of a fire. This meant the effectiveness of these doors to hold back smoke in the event of a fire had been reduced.

We saw from the records the fire alarms were being tested on a weekly basis. The last test had been completed on 23 January 2015 and reported as being 'satisfactory.' We asked the handy person if they checked the fire doors following these tests to check they were closing properly and they told us 'not always.'

We saw the fire extinguishers had been serviced on 12 January 2015 but could not find any service records for the fire alarm system. The registered manager told us no service had been completed.

We saw people's personal fire evacuation plans contained inaccurate information. For example, one person's file stated they were in room 7, the evacuation plan stated they were in room 9 when actually they were occupying room 29. This meant in the event of a fire staff would have misleading information about what room this person occupied.

Following our visit we raised our continuing concerns in relation to fire safety with the West Yorkshire Fire Service.

When we visited in September 2014 we were concerned not all of the people using the service could have a bath or a shower, because the facilities were not suitable. We told the provider to make improvements by 24 October 2015. On this visit the registered manager told us the shower had been out of use for approximately three weeks, as it was being turned into a wet room. The handy person told us they were waiting for flooring and tiles to be supplied by the provider. The providers representative visited during the inspection and said the flooring would be arriving the following day. This meant since our visit in September 2015 two people living at the home, who cannot use the bath, had not been able to have a shower.

At the last visit in September 2014 we found some bedrooms did not have any hot water and in others the water was only warm. On this visit we found bedrooms where the water was in excess of 60 degrees centigrade. This meant it was too hot and could scald someone using the service or staff.

At the visit in September 2014 we saw the gas safety record of inspection had been completed by an external contractor in November 2013 and an electrical installation report dated 14 September 2009 which stated the electrical installation overall was unsatisfactory. We saw defects had been identified in both reports. We told the provider to rectify these by 24 October 2015. On this visit we found again there was no up to date gas safety certificate or electrical installation certificate. The registered manager told us the contractor had been out in relation to the electrical installation but would not issue a certificate as more work needed to be completed. The handyperson also told us they could not fit anymore electrical fire door closures as the system would not take the additional load. We also noted in nearly every bedroom multi plug extension leads were being used to accommodate all of the electrical items in the rooms.

Following our visit we contacted the Health and Safety Executive to report our concerns about the hot water temperatures and gas and electrical safety at the service.

Inadequate

Is the service safe?

At the visit in September 2014 we told the provider to make improvements to unsafe flooring. On this visit we saw the carpet in the dining room had been replaced. However, there was a large 'ripple' in the floor covering and the carpet was coming out of the gripper that ran the full length of the room. Both of these faults were presenting a trip hazard to people living in the home and staff. In September 2014 we also identified the corridor carpet had splits in it, again posing a potential trip hazard. The same carpet was in place on this visit and numerous splits were noted. These had been stuck down to reduce the trip hazard, but the carpet still needed to be replaced to ensure the risk to people was reduced.

On the day of the inspection the temperature around the building was variable. The lounge and dining room were warm as were some of the bedrooms. However, other areas of the home were cold and we noted additional heaters were present in some of the bedrooms. One person was sitting outside their bedroom and drew our attention to a cold draught; we also noted a cold draught coming through the windows in some bedrooms.

When we looked around the building we saw there were emergency call bell pull cords in each bedroom. In two rooms we saw these had been lengthened with wool and in another with a piece of paper towel. In two rooms we saw the red cords had been replaced with white cords, which made them look like a light pull. In one bedroom the occupant was in bed and could not reach the emergency call bell cord. We asked them how they got assistance and they told us they had to shout. We asked the registered manager if there were any extension leads available for the emergency call bells and they told us there were not. The system only operated by pull cords.

In one of the toilets we saw the emergency pull cord was broken and could not be reached by anyone using the toilet. In another toilet and one bathroom we saw there were no emergency call points. This meant anyone using these facilities would not be able to summon assistance if required.

We saw one of the bedrooms was full of builder's materials that were being used to refurbish the shower room. These included a saw and power saw. This room was not locked and could have been accessed by anyone using the service.

This meant that the provider had not met the requirements of the warning notice and continued to breach Regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we visited in September 2014 we found areas of the home that were not clean and asked the provider to make improvements. In their action plan they told us they would make improvements.

Following our last visit we asked environmental health to visit as we found the kitchen was dirty. We saw inspectors had returned on 27 January 2015 and had found improvements.

We looked around the building and found some areas that were not clean. Tops of wardrobes, pictures and mirrors were thick with dust and there were cobwebs in some of the rooms.

The lounge and two bedrooms smelt of stale urine and in two bedrooms we found commode pots with urine in them.

We saw two protective pads for the bedrails and two commode covers had splits in them. This meant they could not be cleaned effectively. We found two mattresses that smelt of stale urine, a toilet brush with faeces on it and a dirty non-slip bath mat in the Parker Bath.

Following our visit we raised our concerns with the Local Authority's Infection Control team.

This meant the provider continued to breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the accident and incident records from our last visit in September 2014 and found there had been three incidents that should have been reported to safeguarding and to the Care Quality Commission that had not been. These included someone who was sitting at the dining table in a wheelchair with the brakes on, who was subsequently found laid on their back. The entry on the accident report queried if they had pushed the wheelchair over backwards. The incident was not witnessed by staff. The other two incidents concerned the same individual and are detailed in the responsive section of this report. Following our visit we referred these incidents to the local

authority safeguarding team and also advised them that staff had not been reporting incidents to them. We also made four further referrals based on other observations during our visit.

If safeguarding referrals were not being made this meant external agencies were unable to consider the issues raised in order to decide if a plan to keep people safe was required. This put people at continued risk.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found there were safe arrangements in place to manage controlled drugs and for the ordering of all medicines. We saw medicines were kept securely in a locked clinical room and medicines requiring cold storage were refrigerated. The fridge and room temperatures were monitored daily, however records showed temperatures were outside the safety range stipulated in the home's medicine policy. For example, fridge temperatures on six occasions were below two degrees centigrade, the minimum recommended temperature, and room temperatures were above 25 degrees centigrade on three occasions. When we asked the deputy manager what the temperature range should be for the room and the fridge they did not know. Extremes of temperature can adversely affect the therapeutic properties of medicines, which placed people at potential risk of harm.

We observed staff administering medicines and this was carried out sensitively and patiently with people given the support they needed. However, we had concerns about the medicine administration records (MAR). We looked at the MARs for five people with the deputy manager. Two people were prescribed an anti-psychotic medicine on an 'as required' basis. The deputy manager told us the GP had reviewed this medicine for one person and advised the dose should be reduced over a six week period and then discontinued and this was recorded in the care records. However, there were no instructions on the MAR chart to show how the dose should be reduced and the home had not received any written confirmation from the GP about this change. Similarly, the deputy manager told us and records showed, the other person had been reviewed by the mental health team who had given advice on when to administer the anti-psychotic medicine, yet there were no instructions about this on the MAR chart. There were no protocols in place to inform staff in what circumstances this medicine should be administered or the maximum dosage and frequency. The deputy manager confirmed there were no protocols in place for any 'as required' medicines. The lack of clear instructions about when 'as required' medicines should be given meant people were at risk of not receiving their medicines when they needed them or being given them too frequently.

We saw there were no times recorded to show when people had received analgesics, such as co-codamol. This meant people were at risk of being given their analgesics without a sufficient gap between doses. The deputy manager told us times had previously been recorded but this month the analgesics had been included in the dosette box instead of in a separate box which meant it had been missed.

The MAR charts showed two people were prescribed creams. For one person the body maps on the MAR had not been completed to show where the cream should be applied. The other person had been prescribed Cavilon cream, however, there was no MAR to record the application of this cream. When we looked in this person's bedroom we had seen a different prescribed cream. This cream had no prescription label. The MAR showed this cream had not been prescribed for this person and this was confirmed by the deputy manager. We saw this person in the lounge and they were scratching themselves vigorously as if they were itching. We raised this with the deputy manager and expressed concern that the cream that had not been prescribed for this person may have been applied by staff and caused the itching. The deputy manager said they would investigate this.

The home's medicine policy was out of date and referred to out of date best practice guidance. We found a pharmaceutical reference book, The British National Formulary (BNF), available for staff was five years out of date. This meant staff did not have access to up to date information and advice about medicines and placed people at risk.

The registered manager told us medicine training for staff was updated annually, however the training matrix showed four staff had not received training in the last twelve months. The registered manager confirmed none of the nurses undertaking administration of medicines had had their competencies checked.

Inadequate

Is the service safe?

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed three staff recruitment files. We found checks, such as criminal record checks from the Disclosure and Barring Service (DBS) and references, were obtained before staff began work. However, we saw one staff member had not provided a full employment history on their application form. The interview notes did not show that this had been explored with the staff member and it was unclear who had conducted the interview as the record was not signed. Two references had been obtained however one had not been fully completed and the other stated they would not re-employ the staff member. There was no evidence to show this had been looked into and when we discussed this with the registered manager they were not able to give any further explanation. For another staff member, their employment history was incomplete, there were no interview records and one of the references had been supplied by the registered manager. This meant staff had not been fully checked to make sure they were suitable and safe to work in a care service.

This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we visited in September 2014 we were concerned there were not enough ancillary staff on duty to take care of the cleaning. Since that visit the domestic hours had been increased and additional hours had been allocated for assistance with washing up in the kitchen. However, even though the domestic hours had been increased there were still areas of the home that were not clean. This meant there were still insufficient cleaning hours available to ensure the home was kept clean.

At the time of our visit 15 people were using the service. There was one nurse on duty throughout the day and night with two care workers. We looked at the duty rotas and saw over a four week period one of the night nurses had worked two 60 hour weeks and two 48 hour weeks. The registered manager told us they had been trying to recruit a night nurse but had not been successful. We could see from the duty rotas that agency nurses were being used for one or two nights each week. This meant the one permanent night nurse was working 12 hour shifts for four or five nights a week.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service effective?

Our findings

We looked at the induction records for three recently employed staff. The registered manager told us they had designed the induction programme a 'few' years ago, which was delivered as power point presentations with questionnaires to be completed afterwards to check staff knowledge and learning. Records showed the induction was completed over one day. We saw one staff member had completed eleven topics in one day and another staff member ten topics in one day. We saw questionnaires had been completed by staff but there was no evidence to show these had been reviewed or marked. The registered manager told us they reviewed the questionnaires. One staff member we spoke with confirmed they had completed their induction over one day. They said they had handed in their questionnaires but had not received any feedback.

The registered manager told us moving and handling training was updated annually. Training records showed 15 staff had completed this training in January 2015. The training records showed seven staff last updated this training in January 2014. One staff member told us they had received moving and handling training on induction and had received an update during the month of the inspection. However, they stated that neither had included a practical session, such as how to use the hoists or other equipment. This was confirmed by the registered manager.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We asked the registered manager if anyone using the service had a DoLS authorisation in place; they told us there was not. Staff told us one person frequently asked to go home or to the pub or wanted to go to work. The individual was not able to leave as there was a keypad lock on the front door and staff had told us the person would not be safe to go out on their own. Yet the registered manager had not considered a DoLS application may be required due to the restrictions in place.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us the food was good. We saw breakfast was a relaxed occasion. Music was playing softly in the background and people were asked individually what they would like to eat and drink. There was a choice of porridge, cereals and toast as well as a cooked breakfast. People were given the support they needed with their meals.

At lunchtime the meal was not well organised and some people waited over 30 minutes to get their main course, by which time others were eating their pudding.

We saw people had been asked about their satisfaction with the meals in December 2014 and January 2015 and for any suggestions. These surveys showed people were happy with the meals being provided.

When we looked at people's care files we saw people had been seen by healthcare professionals such as GPs, speech and language therapists, falls prevention team, chiropodists and opticians. One person using the service told us, "If I want a doctor, they'll bring one in, touch wood never had to get one in." A visitor we spoke with told us staff kept them informed about their friend's well-being and staff had contacted the GP when they were unwell.

Requires improvement

Is the service caring?

Our findings

Some people who had complex needs were unable to tell us about their experiences in the home. We spent time observing the interactions between the staff and the people they cared for. We saw in their direct dealings with people staff approached them with respect.

We also saw things that showed a lack of respect for people. These were some examples; We saw a bed had been made, but the bottom sheet had urine on it. We saw wardrobe doors that were not closing properly and a chest of drawers with a broken handle, that drawer could not be opened. In one wardrobe we saw a note which stated, 'please make sure clothes are hung on correct hangers.' However, we saw clothing in the bottom of the wardrobe which should have been hung up.

When we looked around the home we found people's privacy was compromised because we found toilet and bathroom doors that could not be locked. This meant if people were using these rooms anyone could walk in.

We spoke with one staff member about the care needs of one person who was living with dementia and they told us this person preferred and responded well to male staff and discussed techniques they used to persuade and encourage them with their personal hygiene. None of this information was included in the care plan and we saw the person had a female staff member as their keyworker. This meant the individual's preferences were not being respected.

At 11:25am the Vicar arrived in the main lounge to take Communion Service. The television was switched off, without asking the person who was watching a television programme. People were not asked if they wished to attend the service.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they liked living in the home and said staff were kind and caring. One person said, "The staff are good, they couldn't treat you any better. I'm lucky to be here." Another person said, "I like it here, it's very nice. I can have a bath when I want." A further person said, "Staff are very good and kind."

In four of the five care plans we looked at we found information about people's life history, likes and dislikes, hobbies and interests. This information helped staff to understand them and offer appropriate support. We spoke with one care worker who was able to tell us about the person who did not have this information recorded in their file.

We spoke with one visitor who told us they were made to feel welcome when they visited and found the staff friendly and helpful.

Inadequate

Is the service responsive?

Our findings

We looked at five people's care records. We saw one person had bed rails and bumpers on their bed yet there was no risk assessment in the care records to show how this had been decided.

This person was on a pressure relieving mattress and cushion as their assessment showed they were at very high risk of pressure damage. However, there was no information in the care plan to show what setting the pressure mattress should be. We saw this person was sat on a pressure reliving cushion when sat in the lounge, however when they were transferred to the dining room in a wheelchair for breakfast the pressure cushion was left behind in the lounge chair. This meant the person was sat without their pressure cushion for over an hour. This person was sat in a recliner chair in the lounge, however, it was not clear from the records why this type of chair was being used. This person's moving and handling plan showed their mobility was variable and stated the person could sometimes transfer with two staff and a zimmer frame but when their mobility was poor they required a hoist. There was no information about the type of sling to be used with the hoist. We observed one staff member transferring this person from their wheelchair into a chair using a handling belt and the person's zimmer frame. We saw this person was on a fluid balance chart, however it was not clear from the care plan why this person's fluids were being monitored. The fluid balance charts contained no target input and there was no evidence of the charts being reviewed or monitored by staff.

We looked at the care records for a person living with dementia and found a lack of specific information to guide staff in how to manage this person's care needs. The records showed this person sometimes displayed behaviour that challenged others. Although the care plan contained advice provided by the mental health team about when to administer anti-psychotic medication, there was no specific information about how staff should support and manage this person's dementia and behaviour. We saw behaviour charts were being recorded daily, however it was not clear what purpose they served as they were not referred to in the care plan. The behaviour charts had been written on fluid balance charts with handwritten headings which stated 'sleeping/settled', 'wandersome' and 'agitated' with staff ticking which one applied. We spoke with this person and found they had a wide range of interests and enjoyed conversation which was confirmed by staff. Yet there was no activity plan to show how this person's social care needs were met.

When we looked at the accident reports we saw one person had slipped out of the hoist sling and had been lowered to the floor. We looked at their care plan and saw on the moving and handling plan they needed to use the electric hoist and sling. We saw there were no details of the type or size of sling to be used. We also saw another accident report where the individual had been hit on the leg when the manual hoist had been used which had caused a large haematoma (a blood filled lump). Staff told us the electric hoist was frequently broken. At the time of our visit it was being repaired after being out of use for two days. This meant this person had suffered an injury because the proper equipment was not available to meet their assessed needs.

In another care plan we saw the individual required a soft diet and had been prescribed food supplements because they had a low body weight and were nutritionally at risk. At lunchtime they were given sandwiches. We saw they left the crusts and one of the care workers told us, "They don't eat crusts." We saw the person really enjoyed the chocolate sponge and custard that was served as the dessert. They scraped their dish clean, however, no one offered them a second portion. This meant staff missed an opportunity to provide additional high calorie food to this individual. We asked the deputy manager about their soft diet and they told us the person ate biscuits and sweets without any problems and chewed their calcium tablet.

In the same care plan we saw recorded, "I don't like taking tablets and will hide them under my tongue." We asked the deputy manager about this and they told us the individual would take tablets on a spoon and took them most of the time. This meant the care plan was not accurate and did not reflect the person's current support needs.

In another care plan we saw the individual had been seen by a speech and language therapist who had left instructions that their fluids should be thickened and high risk foods such as crisps and biscuits should be avoided. We saw this person in their room; they had a mug of tea and a beaker of juice neither of which had been thickened. We also heard the care worker offer them a biscuit, mid-morning when more drinks were being served. We

Inadequate

Is the service responsive?

spoke to the deputy manager about this and they told us the individual refused to have their drinks thickened. They also said when their family visited they would eat a biscuit as they were fully supervised.

In the same care plan we saw that the individual was not to be left unsupervised with hot drinks as they had spilt a hot drink on themselves which had caused blistering. We saw this person was not supervised when having hot drinks during our visit. We spoke with the deputy manager who confirmed the person should be supervised with hot drinks. This meant the person was being left at risk of aspirating fluids and scalding themselves because care workers were not providing supervision in accordance with the person's assessed needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us if they had any concerns they would talk to the registered manager and felt they would sort any problems out. We saw the complaints procedure in reception was out of date as it referred to 'The Commission for Social Care Inspection' the previous regulating body. We spoke with a visitor who told us they had made a recent complaint about a member of staff.

When we looked at the complaints log it was empty. The registered manager told us they had dealt with the complaint, but had not logged it. We saw from the provider's monthly reports four further complaints or concerns had been noted. None of these had been documented in the complaints log. This meant there was no record of what staff had done to resolve the complaint and if the complainant was happy with the outcome.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We met with the activity organiser who had started in post in December 2014. This staff member had previous work experience in activity provision and we found they had developed a good rapport with people in the home. We saw they spent time with people on an individual basis and knew what interested them. For example, we heard them talking with one person about sport and saw the person responded well and was smiling. We saw several people laughing and smiling as they took part in a game of bingo which they said they enjoyed and one person doing a jigsaw with a staff member.

Inadequate

Is the service well-led?

Our findings

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This document was not returned to us.

When we inspected the service in September 20014 we issued a warning notice which told the provider they must make improvements to assessing and monitoring the quality of the service provision by 21 November 2014. On this visit we found improvements had not been made.

The registered manager told us they had 12 hours per week allocated to carry out their management duties. They told us the company secretary had told them they had to work these hours when the deputy manager was on duty and not work these hours when the other day nurse was on duty. This meant the registered manager was not able to organise their supernumerary hours around the needs of the service.

No quality surveys have been sent out to people using the service, relatives or staff since our visit in September 2014. One resident and relatives meeting had been held in January 2015, nine people using the service and two relatives attended. The appointment of a new activities coordinator and the menus were discussed. We saw one person asked for rice pudding and this had been incorporated into the menu. One person asked for curry, but this did not appear on the menu.

We saw in the medication administration records file a weekly medication audit sheet which covered controlled medicines, boxed medication and stock medication. These audits had all been signed as correct since 5 January 2015. This meant they were not an effective quality assurance system as they did not identify the problems we found with medication as detailed in the 'safe' section of this report.

We asked the registered manager for the care plan audits and were told there were no audits available. When we looked at the care plans we found they did not always reflect people's current needs. This meant issues with care plans were not being identified through an effective quality assurance system.

We asked the registered manager for the audits of staff supervision and appraisal audits and infection prevention audits. We were told there were no audits in place to cover these areas.

We looked at the environmental audits and found these were focusing on equipment rather than the condition of each room, furnishings and fittings. This meant that many of the things we identified were not being picked up by these audits.

When we inspected the service in September 2014 we saw a joint visit from Calderdale Clinical Commissioning Group (CCG), Clinical Quality Monitoring and Calderdale Council's Contracts Performance and Quality teams had taken place on 1 and 2 July 2014. In both reports recommendations about staff training had been made. In one report it had been recommended one person was trained to become a moving and handling assessor in order to ensure moving and handling assessments were completed appropriately. On this visit we found no one had completed this training. This showed us that despite issues being raised with them, the provider did not take appropriate action to ensure they were addressed.

We were told the provider's representative visited twice a week and we saw their written monthly reports following these visits. Their last report was written on 9 January 2015 following their visits on 29 December 2014 and 2 January 2015. This identified work on the shower room should start within seven days of their visit. It also stated; "The hot water system also inspected to identify specific points within the home that are not functioning at 100%. Alternative solutions still being considered." Following our visit in September 2014 we told the provider they needed to provide a suitable shower facility and to make sure all of the bedrooms had hot water by 24 October 2014. No shower facility was available on this visit and the hot water temperature was too high. This meant the provider had not made the improvements we had asked for.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 15

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 People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 15

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People were not safeguarded against the risk of abuse. Regulation 13

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 The registered person did not ensure there were suitable arrangements for the safekeeping and administration of medication. Regulation 12

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed People who use services and others were not protected against the risks of being cared for by unsuitable staff because had failed to fully explore the suitability of staff before employing them. Regulation 19

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing People who use services and others were not protected against the risks of being cared for by unsuitable staff because had failed to fully explore the suitability of staff before employing them. Regulation 18 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person did not ensure there were suitable arrangements in place for obtaining and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. Regulation 11

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 People who used the service were at risk from not receiving care that met their individual needs or ensured their welfare and safety. Regulation 9

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

This section is primarily information for the provider

Enforcement actions

Treatment of disease, disorder or injury	Suitable arrangements to recognise and respond to people's complaints had not been made. Regulation 16

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 People using the service were not protected against the risk of inappropriate or unsafe care and treatment because the quality systems were not effective and risks were not being identified or managed. Regulation 17

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Suitable arrangements had not been made to ensure people's privacy, dignity and independence were maintained or that people were involved in making decisions about their care or treatment. Regulation 10

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing People who used the service were at risk because there were not enough staff to care for them and keep them safe. Regulation 18 (1)