Donisthorpe Hall

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Inspection report

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Date of inspection visit:
30 August 2016
31 August 2016
09 September 2016

Date of publication:
24 October 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 30 and 31 August and 9 September 2016. Day one was unannounced and days two and three were announced. At the two previous inspections in June 2015 and March 2016 we rated the service as inadequate. At the inspection in March 2016 we found the provider was in breach of six regulations which related to safe care and treatment, staffing, person centred care, quality assurance, consent to care and notification of significant events. At this inspection we found the provider was still in breach of five of the same regulations and was in breach of an additional regulation because they were not meeting people's nutritional needs. The provider had made improvements in one area; they had better arrangements to support staff.

Donisthorpe Hall provides residential, nursing and dementia care for a maximum of 189 residents. Care is provided in six specialist units. The management team told us there were 119 people using the service when we inspected. The home has a longstanding association with the Jewish community in Leeds but also offers care to people of other faiths or beliefs. At the time of the inspection, the service 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.

People who used the service were not protected against the risks associated with the administration, use and management of medicines, and other areas of risk such as pressure sores and choking were not well managed. People did not always receive their oral medicines or creams at the times they needed them or in a safe way. Improvements had been made to the way accidents and incidents were managed.

People told us there were not enough staff and they sometimes received care from staff they did not know. We found the service used a high number of agency staff although the provider had tried to ensure there was better consistency by requesting regular agency workers. Care managers worked on the individual units of the home and were more easily available to people who used the service, staff and visitors. The provider had effective recruitment and selection procedures in place.

People told us they felt safe and staff understood procedures which related to protecting people from abuse and harm and knew they should report any concerns to the management team. The provider had introduced better systems to make sure staff received appropriate training and support to do their job. However, staff did not understand what they must do to comply with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, and did not act within the law.

People who used the service and their family and friends mostly told us they were satisfied with the care although concerns about receiving care from a high percentage of staff that did not know them was a recurrent theme. During the inspection we saw examples of good care practice and poor care practice, and concluded people had different experiences and received inconsistent care. There was a lack of consistency

in how people's care was assessed, planned and delivered. And information about people's history, likes and preferences was not available so staff did not know what was important to people.

Before the inspection we received information of concern from other professionals and some relatives because they felt the service did not always contact health professionals when it was appropriate. We found this was still a problem. The provider had started to introduce a better system to make sure people's health needs were being met and other professionals were made aware when specialist support was needed but the system still needed further improvement to make sure it was effective.

People were comfortable, and lived in a pleasant and well maintained environment. Some people enjoyed a range of social activities; others said they were bored. Opportunities available were not communicated to everyone.

A new manager had been appointed and had introduced some new management systems; these were very recent so there was insufficient information to show if these were effective. Actions to improve the service were sometimes identified but then not followed up.

Opportunities for people to share views and receive feedback about the service were limited. There had been no surveys since the last inspection and meetings were not minuted so it was not possible to find out what people had said and if action was taken to address any issues raised. Information was displayed about how people could make formal complaints but some people were unsure who to talk to if they wanted to discuss concerns.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. We will report on the action taken when it is complete.

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 was a lack of consistency in how risk was managed. People were not protected against the risks associated with the unsafe management of medicines.

The provider had made some improvements to the staffing arrangements but this was not sufficient to make sure people's needs were being met by experienced, skilled and competent staff. Management were more visible.

People were safeguarded from abuse. Staff understood safeguarding procedures and knew they should report any concerns to the management team.

Is the service effective?

Inadequate

The service was not effective.

The provider had improved systems for supporting staff; more effective training and supervision arrangements were in place.

The provider was establishing who was subject to an authorised deprivation of their liberty but they had not communicated this to the staff team. Key requirements of the Mental Capacity Act 2005 were not fully understood.

People had different experiences at meal times. Systems were not in place to make sure people's nutritional needs were met. Other professionals were always consulted when health concerns were identified.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us they were mostly satisfied with the care they received although we observed inconsistencies in how care was provided.

There was insufficient information available to help staff

understand people's history, preferences and what was important to them.

People lived in a pleasant and comfortable environment.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a lack of consistency in how well people's needs were assessed and their care and support was planned.

Some people enjoyed a range of social activities; others said they were bored. Opportunities available were not communicated to everyone.

Information was displayed about how people could make formal complaints but some people were unsure who to talk to if they wanted to discuss concerns.

Is the service well-led?

Inadequate

The service was not well-led.

The provider did not take appropriate action to meet regulations following the last CQC inspection. There were still inconsistencies throughout the service.

A new manager had been appointed and had introduced some new management systems; these were very recent and there was insufficient information to show if these were effective. Actions to improve the service were sometimes identified but then not followed up.

Opportunities for people to share views and receive feedback about the service were limited. There had been no surveys since the last inspection and meetings were not minuted so it was not possible to find out what people had said and if action was taken to address any issues raised.

Donisthorpe Hall

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 over three days on 30 and 31 August, and 9 September 2016. Day one was unannounced and day two and three were announced. Day three's main focus was to provide feedback to members of the management team about our inspection findings. On day one, four adult social care inspectors, a pharmacist inspector, two expert-by-experiences and two specialist advisors attended. On day two, five adult social care inspectors and a pharmacist inspector attended. On day three, two adult social care inspectors attended. One specialist advisor covered governance and the other specialist advisor covered nursing care. 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 information we held about the service, which included concerns raised by health professionals and relatives. We contacted the local authority, the local commissioning group and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We sometimes ask providers 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. On this occasion we did not ask the provider to complete a PIR.

At the time of this inspection there were 119 people who used the service. We spoke with 29 people who used the service, eight visiting relatives and 28 staff and members of the management team. We observed how care and support was provided to people. We looked at documents and records that related to people's care, and the management of the home such as rotas, staff recruitment and training records, policies and procedures, quality audits and medicines records. We looked at 12 people's care records.

Inadequate

Is the service safe?

Our findings

At the inspections in June 2015 and March 2016 we found breaches in regulation relating to safe care and treatment because the provider did not have systems for the proper and safe management of medicines and they were not doing all that was reasonable to mitigate risk. At the last inspection we rated this domain as inadequate. At this inspection we found similar concerns and have rated the domain as inadequate.

At the inspection in March 2016 we found the provider did not have enough competent staff to meet people's needs. The provider had made efforts to address the staffing problems but a high use of agency staff still resulted in some issues with the staffing arrangements.

We looked at how the provider managed medicines within the home and found they still not do this safely. This meant people did not always get their medicines as prescribed or in a way that met their individual needs and preferences. We looked at medication stocks, Medication Administration Records (MARs) and other records for more than 30 people living in four different units of the home. Two people raised concerns with us about their medicines. One person said they sometimes missed their medicines and another person said staff tried to give their medicine at the incorrect time.

Medicines in current use were generally stored safely in locked cupboards and trolleys. We found supplies of blood testing equipment that were out of date and unfit for use along with dressings, medicines and equipment for people who were no longer living in the home. A nurse confirmed to us that blood glucose test strips (for testing sugar levels in diabetes) had been used that day were past their expiry date. Using out of date test strips may give incorrect results and lead to people receiving incorrect treatment.

The provider used electronic Medicines Administration Records (eMARs), however, the home manager had recognised that the electronic system did not meet the needs of the service and was in the process of changing each unit back to paper MARs. At the time of our visit, one unit had already made this switch. Limited information was available through the eMARs and we asked the home to provide more information for us to review. They were unable to provide the information at the time of our visit, but sent records and information for 24 people five days later. We spoke with staff about the eMAR system who described it as, "A nightmare." They told us information about medicines "dropped off the system" and there was "no overview". They said they were only able to see what medicines were due at a particular round, without being able to review when medicines were last administered. This meant that if medicines had been missed or refused, staff were unaware of this and unable to re-offer them.

Medication records were frequently inaccurate and incomplete. Some medicines were listed more than once, whilst others, particularly those prescribed for use at end of life, were not listed on the MARs or eMARs at all. There were missing signatures on records and it was unclear if medicines had been given or omitted at those times. We raised our concerns with the home manager who carried out an internal investigation, and subsequently confirmed some medicines had been administered but not signed for whilst others had not been given. We saw stocks were not always available and as a result people were not given their medicines, including pain relief, allergy treatments, blood pressure medication and treatment for thyroid problems as

prescribed.

We saw people did not always get their medicines the way they wanted or needed them. One person liked to have their morning medicines at 7am, but on the first day of our visit, they were not given them until 10:51am. Another person had reported that they did not get their medicines and eye drops correctly. Records we saw supported this and an investigation carried out by the home confirmed this person had not received their medicines as prescribed. One person was prescribed regular pain relief, but records showed this was rarely given. On 26 August 2016 this person had also been prescribed strong pain relief to be given before daily wound care and dressing changes, but records showed this had not been given and the bottle supplied was still sealed. Two other people were prescribed strong pain patches which should have been applied once weekly, but records showed the patches were not always changed at the correct intervals and in one case was changed five days after it was due. This meant people may have experienced significant and unnecessary pain. We asked to see records relating to pain scores, but were told these were not always recorded.

We looked at records for the application and use of creams and other external preparations for seven people prescribed a total of 17 products including creams to treat fungal skin infections and barrier creams to help prevent skin breaking down. We found none of the products had been used as prescribed and four people did not have any supplies in stock. This meant people's skin was not being protected and infections were not being treated effectively.

Three people were currently given some or all of their medicines covertly (hidden in food or drinks without the person's knowledge or consent). Arrangements for giving medicines in this way had not been made in accordance with the Mental Capacity Act 2005 or the National Institute for Health and Care Excellence (NICE) guidance for managing medicines in care homes. NICE provides recommendations for good practice around management of medicines. There was no information with the care plans or MARs to tell nurses which medicines were to be given covertly or exactly how and in what circumstances they should be given. It was impossible to see from records which medicines had been given covertly and which had been given with the person's knowledge and consent.

New audit systems were in place regarding the management of medication, these had failed to pick up and address some of the concerns and discrepancies we found. We concluded the registered person was not managing medicines safely. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

We looked at how the provider was assessing and managing risk, and found there was a lack of consistency in how this was done. Some systems were in place to help keep people safe; however, other systems were not effective so people were not protected.

At the last inspection in March 2016, we found the provider did not ensure people's assessments and care plans identified areas of risk and action to help keep people safe. At this inspection we found similar issues. The home manager explained they had transferred individual risk assessments to a paper rather than an electronic system. This process was not complete because we saw some people still had electronic risk assessments.

People had assessments that covered risk relating to showering and bathing, falls, nutrition, pressure care, bed rails and hoisting. We saw examples where the risk to people was identified, managed and reviewed. However, we also saw examples where risk was not appropriately identified and managed. One person was identified as 'high risk of developing pressure ulcers'. They had appropriate pressure relieving equipment

and their care plan stated they needed to be repositioned every two hours. We asked to look at the charts to show the person was repositioned but were told these were not available.

Another person's daily notes stated they had a 'sacral sore' to their buttock and their dressing was renewed. However, there was no wound care plan. We saw from the records and discussion with the nurse in charge the pressure ulcer was improving but still in the process of healing, therefore a wound care plan was an essential record to make sure staff know how to deliver safe care and treatment.

We looked at the wound care plan for one person who had been assessed as having a grade three-four pressure sore. A grade four pressure sore is the most severe type of pressure sore. We found there was no instruction for staff in this person's care plan which indicated how often their dressing should be changed. One member of staff told us this was daily, although the records we reviewed did not indicate this.

It was recorded in the same care plan, 'Please apply Aquacel to cavity'. There were no records which identified how often this treatment should be provided. We saw a daily note dated 19 August 2016 which stated, 'The pharmacy are aware we are out of stock of Aquacel and to deliver as soon as possible. Unable to apply today due to having none left'.

We looked at pain management for the same person. We saw a daily note in their records dated 19 August 2016 which stated, 'She appears to be in pain during cares'. One member of staff said, "It's chronic pain." The wound care plan noted on 10 August 2016, 'Oramorph received and is to be given before dressing change'. The records we looked at showed this had not been administered until 30 August 2016 and paracetamol had been used instead. The advanced care plan for this person dated August 2016 stated they wanted to be pain free.

We looked at two people's care plans which identified they had difficulties with swallowing and found they did not have risk assessments in place to address the risk of choking. One person's behaviour plan dated August 2016 stated, 'Staff need to make sure that [name of person] is not sat with other residents'. At dinner time on the second day of our inspection we saw this person was in the dining room sat next to another person.

Staff wore disposable aprons during meal times to help control and prevent the spread of infection. We saw on day one and day two of the inspection that staff had placed these on people who used the service to help protect their clothing. The provider had a clear policy around the use of disposable aprons where these were only to be worn by staff and not by people who used the service. It was clear from our observations this was not being followed.

We concluded the registered person was not assessing the risks to the health and safety of people who used the service and did not do all that was reasonable to mitigate risk. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

At the last inspection in March 2016, we found accidents and incidents were not always being recorded and reported. At this inspection we found improvements had been made to the way accidents and incidents were managed. An electronic reporting system had been introduced and once completed was reviewed by a senior manager who determined what action was needed; this included referrals to the provider's physiotherapist for advice on interventions needed and the health and safety manager. The home manager also received a weekly summary of all accidents and incidents and the actions taken to prevent future re-occurrence. Care managers who were in charge on the units confirmed this new procedure for reporting was now in place and we were shown several examples on people's computerised care records which showed

how any patterns or trends for people could easily be highlighted. The care records also showed actions taken such as referral to the falls team or GP.

We observed that some potential hazards were well managed. For example, it was hot on the first day of the inspection and several people were sat outside in the sunshine. People wore large hats to protect them from the sun. People could freely walk around areas within their unit and many people accessed the cafeteria which was a central communal point. Staff were vigilant and made sure people who required support were appropriately supervised and safe.

Before the inspection concerns were shared with us from other visiting professionals that some equipment was dirty. We looked at a number of items, which included specialist seating, bed rails and bumpers, wheelchairs and mobile hoists. These were clean and well maintained.

At the last inspection in March 2016, we found there were not sufficient numbers of suitable staff deployed throughout the home. A contributing factor was the high use of agency workers. At this inspection we found there was a continuing high level of agency staff. Some units used less agency staff and had a regular Donisthorpe Hall staff team but other units, at times, operated with a higher percentage of agency staff than regular Donisthorpe Hall staff. For example, on one unit on day two of the inspection, five care staff were working and four were agency, and on another unit seven of the ten staff were agency.

We observed some staff only had limited knowledge about the people they were assisting and they kept handover notes about the person in their pocket. On the first day of our inspection, one agency nurse was working in a unit but told us they had not worked on the unit for about two to three months. On the second day of our inspection an agency nurse said they had worked at the service before but not in the unit. In one unit we were informed the staffing levels were short because a member of staff was absent. A member of staff on duty told us this had been reported the day before but no action was taken to find additional cover. The management team completed a weekly staffing report which showed they were monitoring staffing arrangements closely. We saw they were actively recruiting staff and at the time of the inspection they had ten staff waiting to start. The management team told us recruitment was a high priority and was on-going.

Feedback about staffing arrangements from people who used the service was varied. Some told us there were not many regular staff and they were always busy. They said it was common for care to be provided by agency staff. Others said they received care from staff who knew how to care for them appropriately. Comments included, "They don't have the right people to do the right jobs, they are very unorganised", "I press my buzzer but I can wait a long time, they are very short staffed", "They can take between eight and 15 minutes to come when I press the buzzer", "We have no care, they have no time and no staff", "There are big changes in staff, they use an agency, I don't know their names." A visiting relative said, "I've noticed that staff levels have gone up recently." Another relative said, "There's no one to one care, the staff are overworked."

Feedback about staffing arrangements from staff was varied. Donisthorpe Hall staff told us although there was still a high use of agency staff some of the same workers often covered shifts so there was more consistency. The home manager told us they mainly used the same staffing agency but did have another staffing agency as back up, and they held a file with a summary of the training agency workers have completed. Comments from staff included, "Staffing has been much better", "We see the same agency faces which helps", "Sometimes we can struggle without permanent staff", "There are not enough staff and sometimes we get agency sometimes not. Agency staff is still an issue."

Care managers told us they had been involved in assessing people's needs and dependency using a recognised tool, which can help determine the staffing levels. One care manager told us staffing levels had

recently been increased on their unit in response to this. They said they now had seven instead of five care staff throughout the day to support the nurse and senior staff although this had only happened in the week before the inspection.

We saw care managers now worked on the individual units of the home and were no longer office based. This meant they were more easily available to people who used the service, staff and visitors. The home manager had advised care managers to maintain a visible presence on the units. The home manager told us this was important as they wanted senior staff presence to ensure safety and quality were maintained. Care managers told us they were very busy trying to run the units and introduce the new systems to improve the service.

We concluded that the provider was taking action to address the staffing arrangements but as yet this was not sufficient to ensure there were sufficient numbers of suitably qualified, competent and skilled workers. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

People we spoke with said they felt safe living at Donisthorpe Hall. These were some of the comments people made, "I feel safe, no-one will grab me here", "I am very confident here, if someone tried to hit me someone will defend me here", "I feel safe here. No-one can get in here", "I have no concerns about safety here". One person however, told us, "It's over safe. They come during the night every hour disturbing me. They switch on the light; they tell me it's the law."

Staff told us they had received training so they understood how to keep people safe. Staff we spoke with understood safeguarding procedures which related to protecting people from abuse and harm and knew they should report any concerns to the management team. They told us they were confident any concerns would be acted on promptly. We looked at safeguarding training records which showed staff had completed safeguarding training. Safeguarding incidents were being monitored by the local safeguarding authority. The home manager sent us confirmation that there were three open safeguarding cases at the time of the inspection and they were waiting for confirmation from the local safeguarding authority that a further seven cases could be closed.

Information about safeguarding was displayed in parts of the home, however, this was in staff office areas so not visible to people who used the service and visiting relatives and friends. Having information available to inform everyone helps ensure people know how to stay safe and report any concerns. The home manager agreed to make sure information about safeguarding was accessible.

We looked at recruitment records and found safe recruitment practices were followed. Relevant checks had been completed before staff were employed. We saw completed application forms, proof of identity, references and Disclosure and Barring Service (DBS) checks. The DBS is a national agency that holds information about criminal records.

Inadequate

Is the service effective?

Our findings

At the previous inspection in June 2015 and March 2016 we found breaches in regulation relating to supporting staff and consenting to care. At this inspection we found some improvement had been made and the provider had made sufficient progress to meet the regulation which related to supporting staff. However, they had not made sufficient progress to meet the regulation that related to consent to care. At the last inspection we rated this domain as inadequate. At this inspection we have rated the domain as inadequate.

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

At the last inspection none of the staff or management team knew who was subject to an authorised DoLS. After the inspection the provider contacted us and said they were introducing a spreadsheet for each unit but they were struggling to gather the correct data and were working with the local authority to make sure they had the correct information.

We saw four units had spreadsheets with details of who was subject to an authorised DoLS, and work was in progress to complete the other two; the timescale for completing one of these was not achieved by the end of August 2016 as agreed by the provider in their action plan. We asked staff to tell us who was subject to an authorised DoLS but most did not know. Some told us they did not know; others said they thought everyone in the unit was and others gave specific numbers but were unsure what the authorisation was for. A care manager who was responsible for one unit gave us a spreadsheet which they believed was the current information; this was the same spreadsheet that was given to us at the inspection in March 2016 so was out of date. We concluded that although the management team had progressed the DoLS position in relation to data they had still not worked with the staff team to make sure they understood who was legally authorised under DoLS.

We looked at care plans for 11 people who had been referred to the local authority for a DoLS application. Of these, we found only four people had a MCA assessment; everyone should have had an assessment. We asked a member of staff about three of the care files which contained the DoLS applications, and they confirmed there was no evidence of an MCA assessment. They told us, "They were sent in because of the use of cot sides, not because they didn't have capacity." This meant staff did not have a correct understanding of the purpose of DoLS and the need to complete mental capacity assessments.

The home manager said she was aware there would be some gap in the knowledge of the process from staff and the procedures around assessment of capacity but had contacted the local DoLS team, and in future

they would be using standard documentation for mental capacity assessments. The provider was improving the systems for complying with the MCA but as yet this was not sufficient to ensure staff were acting in accordance with the legal framework for making particular decisions. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need to consent.

We observed the meal experience in four units on the first day of the inspection and in three units on the second day. On the first day we observed, in two units, lunch was well organised and people received good support, enjoyed the food and had plenty to eat. Staff were attentive to people's needs and actively encouraged them to eat. They were given options and the chance to have more of the same or something else if they were still hungry. In two units the meal experience was chaotic and some people did not receive appropriate support. In one unit staff were not clear who was responsible for ensuring people had their meal. We heard one person asked for soup but they had to wait over five minutes before they could get the attention of staff. Another person was shouting from their room asking for their meal. They told us, "I want my lunch they have forgotten me." They then went on to say, "It's not the first time, they forgot me last week as well." A visiting relative on the same unit told us, "Last week about 10 o' clock in the morning [name of relative] was in bed in a dark room and had not been given any breakfast; they had forgotten about her, staff didn't know." In the other unit, just before lunch there was very little encouragement for people to go through to the dining room, lunch was delayed and then people were calling out for their lunch. An agency worker did not know the routine or what to do, and when one person complained about the menu the agency worker did not know how to respond.

On the second day of the inspection the meal experience was well organised in the three units where we observed. However, we saw there was an abundance of staff available to assist; staff on duty commented that the staffing levels were not usual. One member of staff said, "There are normally four carers if we are lucky, today is unusual; it's for your benefit." The home manager told us the staffing levels had not been increased and were in place the week before.

We got a mixed response when we spoke with people about the quality and variety of meals. Some people told us they enjoyed the food but others said they were not happy with the meals. Comments included, "The food is not good, no variety. Every mealtime is the same; more fruit would be nice", "Last night the food was atrocious. I told them and was told a lot of people were complaining but we can't do anything", "I'm happy with what we get served; there is always plenty and at each meal time we get a starter and a dessert". One person told us they did not have the option of a vegetarian meal and had raised this as a concern with management.

People were offered three course meals at lunch time and at dinner. Menus were varied and provided people with a choice. We also saw the 'supper tray' list included a selection of sandwiches, cakes and toast. We observed fruit was available in the units and drinks were regularly served throughout the day.

There had been a number of changes to the meal arrangements which some people felt impacted negatively on the dining experience, which included a change in the food provision budget and a change in the role of dining hosts. The home manager said they were concerned about the dining experience and were monitoring this closely. We saw from the complaints record the changes had resulted in a higher level of complaints.

The management team had introduced a system for people who were at risk of malnutrition. Each unit had a spreadsheet that should identify anyone who has lost weight. We looked the spreadsheet in three units and saw any recorded weight loss was highlighted and action points were recorded to help manage this. However, we found not everyone who had lost weight had measures in place to make sure their nutritional

risk was being appropriately managed. One person had steadily lost weight in 2016 and had been under the care of the 'dietetic services' and was last reviewed by them in January 2016. They left clear instruction that if the person continued to lose weight the service should contact them again. This should have happened in April 2016 but did not. The care manager agreed to contact the dietetic service straightaway.

We looked at another care plan and found the Malnutrition Universal Screening Tool (MUST) for this person was not completed. They were recorded as having lost 7.5 kg between December 2015 and August 2016. This person's daily food intake was being recorded although no referral to the dietician had been made. We raised this concern with the member of staff in charge. On the second day of our inspection we received confirmation a referral to the dietician had been completed.

Staff told us food and fluid charts were completed when people were at risk of malnutrition. We looked at three people's charts and found these were not being completed correctly, and the information on the records indicated people were not getting enough to eat and drink. For example, one person's fluids were being recorded and over a 13 day period the amount ranged between 50mls and 900mls. The Health Organisation Guide suggests 1.6 litres of fluid per day for a woman. We found the person on most days did not receive half of this recommendation.

We saw one person's recommendation from the dietetic service was to 'give milk shakes during the day if not eating'. We also saw from a recent 'weight' action plan that fortified meals and fortified snacks should continue to be offered. The comments included offering 'smoothies, cakes, double cream etc. Smoothies are nutritious drinks'. The chef told us all meals were fortified which means adding nutritional value to foods.

Staff in the kitchen told us they did not have records of people's special dietary requirements for one of the units. We asked about the texture needed for fork mashable diets and found the records in the kitchen did not include this information. One member of staff told us, "They are all under review." The home manager said they were working with catering staff to make sure they had all the necessary information about people's dietary requirements. We concluded the provider did not have suitable arrangements in place to make sure people's nutritional needs were met. This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs.

Before the inspection we received information of concern from other professionals and some relatives because they felt the service did not always contact health professionals when it was appropriate and when health professionals were involved their recommendations were not always followed. Some professionals had also raised concerns because when they visited staff did not know the person.

The provider told us they had introduced a new protocol to help make sure communication with professionals improved. We found only parts of this had been implemented. Reception and unit staff understood they needed to make sure staff from the relevant unit were contacted when other professionals visited. However, when we looked at documentation it was difficult to sometimes find out when health professionals had visited. The provider told us a health/social care professional signing in book would be in place but this had not been introduced. It was difficult to find who had visited from the general signing in book because over a five day period over 300 people had signed in.

The provider told us health professionals would write recommendations and communications in the person's care plan folder but we saw this was not happening consistently. Sometimes these were completed and sometimes they were not. We spoke with a member of staff in charge of one unit about the records and they did not know the care plan folder should be used for health professional visits. When we looked at

people's care records we found professional's notes were not always completed and to find out if any visits had been carried out you needed to go through people's daily notes. The home manager told they were meeting with a health practice to help improve the current system.

We saw examples in people's care records where staff made referrals to other professionals when it was appropriate to seek additional advice but we also saw examples where this had not been done. One person should have been referred to dietetic services but this had not happened. Another person's pressure ulcer had deteriorated but the staff team had not referred the person back to the tissue viability nurse.

We were told by a member of staff one person had not been given Parkinson's medication for at least two months as this had been stopped. However, there were no records in the person's care plan which referred to this change. We saw the same person's 'current medical history' section of their care plan dated August 2016 named a medicine they should have received specifically to treat Parkinson's. The physical health care plan dated August 2016 stated 'She sometimes takes her Parkinson's medication but will refuse other times'. There was no reference in the person's records that this was discussed with other healthcare professionals. We brought this to the attention of the manager who told us they would look at this immediately. We concluded the registered person was not assessing the risks to the health and safety of service users and did not do all that was reasonable to mitigate risk. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

The provider had a training record which covered a range of sessions; these included manual handling, first aid, fire safety, safeguarding, information governance, equality and diversity, nutrition and hydration, and basic life support. The training record showed training and development had improved since the last inspection. Evidence was provided to demonstrate a higher level of attendance at mandatory training. Management provided an explanation where the training records indicated the training status had expired for any member of staff.

Staff said they were given opportunity to receive mandatory training and some specialist training. Several said they had recently attended the care certificate' which is an identified set of standards that health and social care workers adhere to in their daily working life. There was a mixed response when we asked staff about dementia and end of life training; some said they had not received these sessions. The training record did not included end of life training and had not captured all dementia training. A member of the management team said between June and August 2016, 30 staff had attended end of life training and 66 staff had attended dementia training. On day one of the inspection, an external facilitator was visiting the service to plan training around tube feed and nutritional drink supplements. This was going to be attended by the unit's nursing staff and two agency nurses who worked on the unit on a regular basis. The external facilitator told us, "I have no problems with the home, always get a warm reception and staff listen to me."

There was evidence held centrally that a higher level of supervision was being provided to staff. Supervision is a formal process to support staff, which includes a meeting with a supervisor at least every three months. Supervision trees had been introduced and identified who was responsible for supervising staff. Staff said they received supervision although some said this had not happened as often as it should. We reviewed staff files for four staff and found two staff members had received supervision as per the described policy. However, two had not received their planned supervisions for August 2016. A member of the management team explained the appraisal cycle commenced in October each year so would start in the next few weeks. We concluded that progress has been made since the last inspection. The supervision system had been reviewed and there was a clear policy for delivering supervision; they were not yet achieving this consistently but were working towards it.

Requires Improvement

Is the service caring?

Our findings

At the last inspection we rated this domain as requires improvement. At this inspection we found similar concerns and have rated the domain as requires improvement. People who used the service and their family and friends mostly told us they were satisfied with the care although a number of people raised concerns about receiving care from a high percentage of staff that did not know them. Comments included, "They try to keep me moving and encourage me to use my walker rather than my wheel chair", "I felt a little isolated when I was in another unit so they moved me here they are very good to me", "They look after [name of person] very well", "I'm very happy with her care, they are very kind to her".

During the inspection we saw varied care practices. For example in one lounge just before lunch we observed two different approaches. One member of staff approached one person and said, "Hello, its lunch time would you like to go for lunch." Whereas another member of staff spoke abruptly and said to another person, "Come on [name] it's lunch time. I'm going to take you to lunch." We observed a member of staff at lunchtime assist a person to eat but they did not talk to them and other interactions where communication was very limited. One person who was blind had no disability specific equipment to assist. We observed staff enter their room but they did not introduce themselves by name. On one occasion we saw a care worker enter the room and talk to the person. The person told us, "I know the voice but I don't know who it was."

We saw several examples of good practice where staff were kind and caring in their approach, and explained to people what they were doing. One member of staff administered medication and went through everything step by step with the person. Another member of staff was seen to offer lots of encouragement for a person to join an activity. Later on we observed the person clearly enjoying this.

During meal times we noted some people were wearing protectors to keep their clothes clean. We noted in one unit some people were wearing tea towels whilst they were eating; we were told this was because they had been waiting for aprons for the last four to six weeks. Wearing tea towels was usual practice in this unit but no-one had considered or recognised this as a dignity issue.

We saw that a handover sheet had the same note each day in relation to one person which stated, 'If it is ok with [name of person] please dress her on her bed and leave comfy and day staff will assist her out'. Staff on duty said they did not know why this note was on the handover sheet because day staff usually assisted the person which included dressing. They said they were unaware of any person being dressed by the night staff and then being left on their bed until day staff arrived. Staff we spoke with said this practice did not happen in the home and recognised this was not personalised care.

We visited all six units and saw people were comfortable in their environment and had opportunity to walk freely around their unit. Some people spent time in their room and others spent time in communal areas. People spent time in the foyer where there was the main reception, a café and several seating areas. We observed people reading newspapers, enjoying a drink and snack, and chatting and enjoying the company of visiting family and friends and others they lived with. Members of staff and the management team often stopped and chatted to people.

All areas of the home were well decorated and furnished, and throughout there were items displayed that created a homely environment. In one unit which was for people with dementia we noted there was a shelf with six different types of clocks. These did not work and all were stopped at different times so if a person looked at them they would not know the time and would find it confusing, therefore, this was not an appropriate display for people with dementia.

The home has a longstanding association with the Jewish community in Leeds. There was a synagogue on site and all meals prepared met Jewish dietary requirements, known as Kosher. The service also offered care to people of other faiths and beliefs.

We looked at care records to find out how staff understood people's history, likes, preferences and needs but found there were inconsistencies in the information that was available. We selected six computerised records and found only one file had any life history information. We were told people had life history books that were kept in their room so we looked at the arrangements in two units and found these were not in place. In one unit we visited six rooms and found no life history information. One person had a blank book in their room and the others had no books. A member of staff on the unit said people had chosen not to complete these. In another unit we looked in three people's room and found only one person had a life story book. They also had a 'one page profile' which provided key information about the person. We found there was a high usage of agency staff, therefore, having up to date information was very important when staff were not familiar with the person they were supporting.

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection in June 2015 and March 2016. We found breaches in regulation relating to person centred care. Some people's care plans did not identify how care should be delivered and had not been updated when their needs had changed. At the last inspection we rated this domain as requires improvement. At this inspection we found similar concerns and have rated the domain as requires improvement.

We found records about people's care needs were not stored in one place and it was difficult finding all the relevant information. It took an excessive length of time to review the records and we concluded a new member of staff or agency worker would not have time to sit and look at these to find out how to meet the person's needs.

There were inconsistencies in the system in use; some people's risk assessments were on the computer and others were on paper and kept in a care plan folder. We were told all care records were being transferred from the electronic system to a paper based system because the electronic care planning system was not fit for purpose; the transfer was in the early stages.

We reviewed 12 care plans and shared concerns with the home manager about the care and safety of six of those people. The concerns related to a lack of information about how people's needs should be met and the measures in place to help keep them safe. Some information was out of date. One person had been in hospital for eight weeks and their needs had changed; their care plan had not been updated. The care manager agreed to write a new care plan.

We looked at two people's behaviour care plans and found these provided very little information to help guide staff. The care plans only used terms such as 'can become agitated and frustrated' and 'offer explanations and reassurances at these times'. There was no information about potential triggers, patterns or de-escalation techniques. We concluded a new member of staff or agency worker would not know from the care plan how to support people when they displayed behaviours that challenged.

We got a mixed response when we asked staff about the care planning system. Some said people's care records were personalised but most said the records were not accessible and it was difficult finding out about people's care needs so they relied on handovers, senior staff and colleagues. We asked 11 care workers about accessing care plans; six told us they did not read the care plans.

We saw people's care plans had been evaluated however, there were inconsistencies in the frequency of these and no explanation as to why some were being reviewed less often. For example, one person's nutrition plan was reviewed in February and May 2016, and their eating and drinking care plan was reviewed in March and July 2016. Members of the management team told us they had introduced a new system called 'resident of the day', which would ensure people's care was reviewed monthly. This involved allocating a day each month to a person and then reviewing their information to make sure it is up to date. Some staff we spoke with did not know about resident of the day and this had not been explained to them.

There was very little information to show people had been involved in the care planning process and people we spoke with confirmed this. The home manager said they were introducing a new care planning system because the current electronic format was not accessible to people and difficult to follow. The home manager told us the focus of the new style care plans would be to involve people and ensure they were consulted about how their care should be delivered. Although they had not started the new care plans the home manager said these would be rolled out soon after the inspection. We concluded the care and treatment of people who used the service was not always assessed and planned in a way that ensured their needs were met. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

People had different experiences around social activities. Some said they had opportunities to go out and enjoyed attending entertainment sessions; others said they were bored and didn't get chance to go out or engage in activities. Comments included, "I have been to most of the outings", "I like dancing", "I pay a lot of money but I don't want to tell my relatives that I don't do anything. I don't want to trouble them", "I feel lousy. There is nothing to do. I can't see and can't read the board. They do read to me but always rushed", "I have read half the books in the library because I am bored. It's residential but look around I am surrounded by people I can't even talk to", "I enjoy getting my hair and nails done", "I enjoy the table tennis; there're not many residents take part but some people come in to play", "We play dominoes here in the garden when it's sunny". A relative said, "Entertainment has improved in the last four months they are trying different activities."

The range of activities available to people was on display in the home. During the inspection we saw some activities were well attended and others were not. For example, a film afternoon was attended by two people; a person who used the service and their relative. Another day there was a live band playing various types of music; this session was well attended. In one unit we saw people sat for long periods with very little staff interaction and stimulation. In another unit there were computers with internet access, and we observed one person spending time on a computer. People had access to a library where they could borrow books. The home manager explained that they were reviewing some placements because they had identified some people were not appropriately placed, which may address the concerns raised about people being unable to communicate with others they lived with.

Most people we spoke with told us they would raise concerns but some were unsure who they should talk to. Some people told us they had raised concerns but the issues were not addressed. One person said, "It's difficult to know who to talk to, the carers say leave it with me but nothing is done." Another person said, "I have spoken to management, I can't be bothered anymore. I can't be bothered to move either." Two visiting relatives told us they had been contacted by the new care manager to arrange a meeting. They both said they were confident the care manager would respond to concerns. One said, "I've have a meeting with the new manager, it was a very positive meeting, we went through the care plan and discussed all the problems the home has. I believe things will change for the better, some things have improved but It's too early to say for certain if they will be continued."

The complaints procedure was displayed in the home and people had a copy in their room. Since the last inspection the provider had changed the timescale for responding to complaints from 14 days to 28 days; the home manager said this was more effective because it gave them opportunity to investigate thoroughly, respond and report. The provider had also introduced a more effective system for gathering and analysing complaints and compliments.

The complaints analysis report for 2016 showed the provider had received six complaints in April and May, eight in June, five in July and ten in August 2016. The report identified the nature of complaint, the relevant

unit and who was responsible for carrying out the investigation. Individual complaint records contained details of the investigation and outcome. We saw recent complaints had been raised around care delivery, medicine management, staffing, healthcare, safety and care records.

The compliments analysis report for 2016 showed the provider had received three compliments in April, July and August, seven in May and four in June 2016. The report identified the nature of compliment and the relevant unit. We saw recent compliments related to individual members of staff, activities, birthday celebrations and improved communication.

Inadequate

Is the service well-led?

Our findings

The service did not have a registered manager. A home manager was appointed in July 2016 and told us they had commenced the CQC registered manager's application process and would be submitting this shortly. The home manager was supported by a management team, which included three care managers, a social care manager, estates manager, head of human resources and a compliance manager. A clinical lead was providing cover between two and three days a week. The registered manager said they were looking at the management structure and were in the process of recruiting a deputy manager and full time clinical lead. Each unit had a designated care manager who was responsible for the day to day management.

At the last inspection we found breaches in regulation relating to good governance because the quality assurance systems were not effective. There was a lack of consistency in how the service was being monitored. At this inspection we found there were still inconsistencies throughout the service. We saw a number of records that indicated the service had started to make improvements but these changes were only very recent. We were made aware that since the last inspection in March 2016 there had been a number of changes in the management arrangements and this had impacted on the progress made. We concluded that the provider was establishing systems but as yet these were not operated effectively, and therefore they were still in breach of the same regulation. At the last inspection we rated this domain as inadequate. At this inspection we have rated the domain as inadequate.

We got a mixed response when we asked people who used the service and visiting family and friends about management and leadership. Most people did not know the name of the home manager or manager responsible for their unit. Comments included, "I don't know who the management are I've never seen them", "Management and staff are changing all the time. We can't build a relationship up with the staff", "There is new management but no improvement", "I can't be bothered with management anymore; they don't listen".

We got a mixed response when we asked staff about management and leadership. Some felt the service was well managed whereas others did not. Some said changes were being made which were positive but others told us things had not changed. Several members of staff said they felt the home manager would improve the service, and managers were more visible although most could not tell us what the actual management arrangements were. Comments included, "The care manager on the unit is much better, more supportive", "Managers are trying to do a good job", "I don't really feel much of a change within the organisation. Staff seem a little more focused but apart from that it is all done behind closed doors. We didn't know they were painting the doors on the unit until they came to paint them. I feel each unit is run separately", "The new manager is organising things", "Nothing has changed over the last few months", "Nothing is different from the last time I was here", "Communication is a bit better and having the care manager available".

Some new auditing systems had been introduced. We looked at falls audits on two of the units. These had been introduced in the last month. On one unit the care manager had identified action such as staff training but had not yet developed an action plan to say how this would be addressed. On another unit actions were identified but the action plan in place was not clear or specific. For example, medication reviews were

identified as needed to prevent falls yet there was no information documented as to how this would be done and for whom.

The home manager told us they had real concern around meal times and had been focusing on improving people's experience. We saw dining experience audits had been completed in the last month on two of the units visited. The frequency of the audits had been increased to weekly on one of the units as recurrent themes were identified. Recurrent themes included; dining area not clean or free from clutter, plates not warm for hot food, not cold for cold food, food servers not organised and focussed on the meal time experience, people not offered or shown choices available, food not presented attractively, people not asked if they enjoyed their meal and food servers not being attentive to people during their meals.

One of the care managers had developed an action plan with the action identified as 'Training for staff on mealtime experience' with a date for completion of 1 September 2016. There was no plan for how this was to be completed. The care manager said they had met with the head chef to discuss concerns and had undertaken several meetings with the staff team to say what needed to improve and how they and the kitchen staff needed to work as part of a team to improve the dining experience. These meetings were not documented.

The dining with dignity audits were not available on two of the units we visited. The nurse in charge said they were aware there was "a lot going on with the dining experience" and another staff member confirmed the audits had been carried out. The home manager provided an action plan which they said had been developed in response to the audits on these units but as the audits were not available we could not confirm this. Actions included; 'to arrange for adapted cutlery and crockery', 'tumblers available for cold drinks' and 'tables to be set correctly prior to the meal commencing.'; these had not been signed off as completed. On one unit the senior care worker in charge said they had never heard of the dining with dignity audits. They said nothing about this had been discussed with them. This showed there was not a consistent approach to auditing and action planning.

We found there was an inconsistent approach to the way mattress audits and mattress cleaning was carried out. On one unit, the nurse in charge said mattress cleaning took place weekly and mattress audits were undertaken monthly on all mattresses. The cleaning record showed 14 mattresses were cleaned on 11 June 2016 but records for the other seven mattresses on the unit were left blank. There were no other record sheets for cleaning of mattresses in the file. The nurse in charge could not explain this. On another unit, there were 14 beds; five mattress audits had been completed on 10 July 2016. Four of these records were incomplete with a section of the audit missed out and one section was completed wrongly which meant the audit was ineffective. No other mattress audits had been carried out since 10 March 2016 which meant the home's policy was not followed. We looked at mattress audits for the last three months on another unit and these showed they were completed correctly each month. Actions were identified and the audits showed what was done in response, for example, 'mattress replaced.'

In the last month, the home manager had introduced a key performance indicator (KPI) reporting system. We were told care managers completed a weekly report from each unit/area of responsibility and this was forwarded to the home manager. The weekly reporting included information on pressure sores, weight management, accidents, hospital admissions, infections and medication errors. Care manager KPI reports were reviewed and showed they were completed and submitted to the home manager to ensure they had an overview of how the units were performing. The reports also included information on complaints and compliments and any staff issues. The reports showed actions were taken such as meetings with complainants and moves to appropriate units for people who used the service.

The home manager told us they captured the data from each unit's KPI reports and produced a monthly generic overview action plan for the home to ensure the on-going improvement. The home manager commented several times throughout the inspection that these new systems of auditing and reporting were in early stages and they were aware there was much still to do.

In response to the findings of our last inspection we were told by the provider that there were action plans on each of the units developed from the local audits. On one unit we visited we were told action plans had yet to be developed in response to the audits undertaken in the last month. On another unit we saw the action plan was not detailed and robust to show clearly the actions needed to ensure improvements in the service and did not link to the outcome of other audits conducted, for example, medication and dementia. On another unit we saw a more detailed action plan.

The home manager informed us that weekly quality of care meetings took place with the care managers and we looked at some of the minutes of these meetings. We noted they had not always occurred weekly and the home manager acknowledged this saying holiday and other matters had sometimes taken precedence. We saw the discussions in these meetings included the newly introduced key performance indicator (KPI) system, the dining experience, wound care, medication issues, cleanliness, recruitment and staffing, residents' files, dementia care audits, safeguarding, complaints, processes for accident and incident reporting and care plan evaluation system.

The provider held a staff forum where representatives met with management and communicated views and ideas. We saw the minutes from July 2016 which showed the terms of reference and role of a representative had been agreed. The provider told us staff drop-in sessions were held once a week and notes were made of staff comments and concerns, and these were then shared at senior management meetings and using the staff noticeboards. We saw from records the drop-in sessions started in April but the last one was held on 19 July 2016.

People told us they had attended meetings to discuss the service and had opportunity to put forward their views. However, when we asked members of the management team to look at the meeting minutes we were told they had been advised not to record the meetings so no minutes were available. We were told no surveys had been carried out since the last inspection. We concluded the provider did not have systems that were effective to assess, monitor and improve the quality and safety of services. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

At previous inspections we reported the provider had not always notified us about important events. It is an offence not to notify CQC when a relevant incident, event or change has occurred. At the last inspection we found the provider had notified CQC about some significant events such as deaths and serious injuries, however, they had not sent any notification of abuse or allegations of abuse. We dealt with this breach separately and issued a fixed penalty notice for failure to notify us of notifiable incidents.