CCA & Mrs C Bolland

Laurel Bank

Inspection report

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Date of inspection visit:
07 February 2017
10 February 2017

Date of publication:
16 March 2017

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

Summary of findings

Overall summary

This inspection took place on 7 and 10 February 2017 and was unannounced.

We inspected this service on 6 July 2016 and rated it 'Inadequate' and in 'Special Measures'. We found five regulatory breaches which related to staffing, consent, dignity and respect, safe care and treatment and good governance. We took enforcement action and issued warning notices for the breaches related to safe care and treatment and good governance. The warning notices stated the provider had to address these breaches by 31 August and 1 September 2016 respectively. Following the inspection the provider sent us an action plan which showed how the breaches would be addressed. This inspection was to check improvements had been made and to review the ratings.

Laurel Bank provides accommodation and nursing care for up to 37 older people. The property is a converted house which has been extended. Accommodation is spread over two floors and includes single and shared rooms. There are a variety of communal areas including lounges, a dining room and an enclosed garden. There were 25 people using the service when we visited.

The home has a registered manager who has been in post for many years. 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.

Overall although we found new systems and processes had been put in place since our last inspection to improve the service we found these were not effective and people were not receiving the care and support they needed. Feedback from people and relatives was mixed with some expressing satisfaction with the care whereas others raised a number of concerns.

Some improvements had been made to the way medicines were managed. For example, better storage arrangements were in place and all the nurses had been trained in medicines and had their competency assessed. However, we found concerns still remained in relation to medicines given on an 'as required' basis and nutritional supplements.

Risks to people were not well managed particularly those relating to people falling and their nutritional needs. For example, we found one person had sustained several falls yet assessments had not been reviewed or updated to look at how these risks could be reduced and managed. Similarly the risks to people who had lost weight or who were low weight had not been assessed and managed to ensure people were getting enough to eat and drink.

Some people told us they didn't feel safe and they felt there were not always enough staff. We found there were times when there were no staff in communal areas. The registered manager was not able to explain or show us how staffing levels had been calculated. We found safeguarding incidents were not always

recognised or reported to the appropriate authorities.

We found some parts of the building were clean and comfortably furnished. In contrast others areas were not. We found two rooms were cold and the water from some of the hot taps was only lukewarm.

We found safe recruitment processes were in place and staff received an induction when they started working at the home. Many of the staff had qualifications in health and social care. Some staff training had been delivered since the last inspection, however there remained significant gaps in areas such as safeguarding, fire safety and dementia care. Systems were in place to ensure staff received supervision and appraisal.

People had mixed views about the food as some said they enjoyed it whereas others did not. Similarly some people and relatives praised the staff, yet others felt there were inconsistencies and described some staff as good but said others were not. People told us they were treated with respect.

People's social care needs were not always met. Although activities were provided which some people enjoyed, other people told us they felt lonely.

A complaints procedure was in place however we found this was not always followed when complaints had been raised.
People's care records were not always accurate, up to date or person-centred. People told us they had not been involved in planning their care. People had access to healthcare professionals however we found this support was not always accessed in a timely way.

People and relatives' views about the registered manager were varied. We saw the registered manager and deputy manager worked with the staff team, however we concluded there was a lack of effective and strong leadership. Quality assurance systems had been put in place however these were not fully embedded or robust which is evident from the continued breaches we found at this inspection.

We found continued shortfalls in the care and service provided to people. We identified nine breaches in regulations. These related to staffing, safeguarding, person-centred care, dignity and respect, consent, complaints, the premises, safe care and treatment and good governance. The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded

The overall rating for this service is 'Inadequate' and the service remains in 'Special measures'.
Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from

operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

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.

Safe and effective medicine systems were not always in place which meant we could not be assured people received their medicines when they needed them.

There were not enough staff deployed to meet people's needs in a timely manner and keep them safe. Safe staff recruitment processes ensured new staff's suitability to work in the care service.

Risks to people's health, safety and welfare were not assessed and mitigated. Safeguarding incidents were not recognised, dealt with and reported appropriately.

Effective systems were not in place to keep the premises clean, secure and well maintained.

Is the service effective?

Inadequate

The service was not effective.

Not all staff had received the training and support they required to fulfil their roles and meet people's needs

The service was not meeting the requirements of the Mental Capacity Act [MCA] and Deprivation of Liberty Safeguards [DoLS].

People's nutritional needs were not always met.

People's healthcare needs were assessed and people had access to a range of health professionals, however this was not always accessed in a timely way.

Is the service caring?

Requires Improvement

The service was not always caring.

People and relatives gave mixed feedback about the staff stating some staff were good whereas others were not.

People described a caring approach which was not person-centred and did not reflect or met people's equality and diversity needs.

Is the service responsive?

Inadequate

The service was not responsive.

Care records were not person-centred and did not always reflect people's preferences and needs.

A range of activities were provided on both an individual and group basis.

Complaints were not recorded, investigated and respond to in accordance with the provider's complaint policy.

Is the service well-led?

Inadequate

The service was not well-led.

The regulatory breaches identified at the previous inspection had not been addressed. Quality assurance systems were not effective in ensuring improvements in the quality of the service.

There was a lack of strong and effective leadership which meant people who used the service received did not receive consistent quality care.

Laurel Bank

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 7 and 10 February 2017 and was unannounced on both days. The inspection was carried out by two inspectors. An Expert by Experience with experience of services for older people living with dementia was also present on the first day of the inspection. 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 home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioning and safeguarding teams and the clinical commissioning group (CCG).

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. The registered provider returned the PIR and we took this into account when we made judgements in this report.

We spent time observing the care and support delivered in communal areas. We spoke with eleven people who were living at the home, five relatives, three care workers, the cook, the activities organiser, a nurse, the deputy manager and the registered manager.

We looked at eight people's care records in depth, three staff files, medicine records and the training matrix as well as records relating to the management of the service. We looked round the building and saw people's bedrooms and communal areas.

Inadequate

Is the service safe?

Our findings

At our last inspection we found medicines were not managed safely. At this inspection we found some improvements had been made, although concerns remained.

We looked at the medicine administration records (MARs) which were generally well completed although we found a number of anomalies. For example, one person's MAR had a handwritten entry for a prescribed cream to be applied 'as directed'. There was no start date for the cream and no signatures to show this had been administered. We asked the registered manager who told us the person did not require the cream and said they did not know why it had been written on the MAR. When we returned on the second day the MAR was unchanged.

On the first day of our inspection we looked at one person's MAR at 12.25pm and saw the morning dose of an antibiotic had not been signed for. When we pointed this out to the registered manager they told us they given it but had forgotten to sign the MAR and then signed it in our presence.

The registered manager told us no one received their medicines covertly yet we saw an entry written on one person's MAR which stated the person received their medicines covertly. When we asked the registered manager about this they said it had been written in error. We saw in another person's daily notes they had been given their medicines covertly when they returned from hospital.

Another person's MAR showed they had no allergies, yet their care records showed they were allergic to Penicillin. The registered manager corrected this when we showed it to them.

We saw the care records for one person showed they had been prescribed two nutritional supplements, one to be given daily and the other three times a day as they were losing weight. We looked at the MARs for this person which had started on 30 January 2017 and neither supplement was recorded on the MAR. This meant we could not be sure this person had received these supplements during this time. When we returned on 10 February 2017 the registered manager told us they had asked the pharmacist to add the supplements onto the MAR.

We saw PRN protocols were in place for most 'as required' medicines, however this was not always the case. For example, we saw one person was prescribed two different sedatives, both of which could be given on an 'as required' basis. There was a PRN protocol for one of these sedatives but not the other. We saw on one occasion the person had been given both sedatives at the same time. There was nothing recorded on the MAR or in the person's care records to show why this person had required both of these medicines. There was no information on the PRN protocol to state whether it was safe for this person to be given both sedatives at the same time. We asked the registered manager about this and they were not able to explain why this had occurred.

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

We found medicines were stored safely and securely. We saw staff ensured medicines were kept in the locked trolley while they were administering medicines to other people. When not in use the medicine trolley was kept in the clinical room which we saw was kept locked. There was a new medicine fridge which was clean and records showed the fridge temperatures were maintained within the safety range, as was the room temperature of the clinical room. The registered manager told us all the nurses had received medicines training from the pharmacist and had had their competency assessed.

We identified concerns with the security and maintenance of the building. On the first day of our inspection we arrived at 8:10am and found the front door was open. We walked into the home and through to the communal areas where people were sat but no staff were present. After a few minutes the registered manager appeared. They told us they did not know why the door had been left open, but made no move to go and secure it until we prompted them to do so. We also found many of the windows in the ground floor bedrooms were able to open wide enough for anyone to climb in or out of them. This compromised people's safety and security.

When we looked round the building we found some fire doors were not closing fully into the door frames. At the last inspection we found the water from the hot taps was not always hot and we found the same issues at this inspection. One person told us the hot water took a long time to come through and although we spent five minutes running the hot tap in their room the water was still only lukewarm. On the second day of our inspection we found the bathroom on the first floor was very cold and when we checked the temperature it was only 16°C. We found one of the bedrooms near this bathroom was also cold and the two people in bed in this room had cold hands. We checked the temperature which was 19.4°C. We took the registered manager to both of these rooms and they agreed the rooms were cold. They arranged for extra blankets to be brought for the people in bed and said they would check the heating. We would expect rooms to be around 21°C or at a temperature the occupants of rooms were happy with.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations

We saw the service's fire risk assessment was out of date having last been completed in 2012. The fire alarms were being tested every week although the emergency lighting test was overdue. However, fire practices were being held at different times of the day and night and when the fire alarm sounded during our visit all staff responded appropriately. We saw Personal Emergency Evacuation Plans (PEEPs) in people's bedrooms and in their care files which gave staff information about what action to take in an emergency.

We saw at the last food standards agency inspection of the kitchen they had awarded them four stars for hygiene. This is the second highest award that can be made. This showed us effective systems were in place to ensure food was being prepared and stored safely. However, the rating was not on display.

Overall we found the home was clean, however there were areas which were not clean and we identified infection prevention issues. We found some carpets were stained and dirty. For example, a carpet in the corridor upstairs and the carpet in the conservatory. The carpet in one bedroom was marked, patched and stained and the person living in this room said, "It's (the carpet) past it's sell by date." Throughout the building we saw damage to the surfaces of furniture and chipped paintwork, meaning these surfaces could not be cleaned effectively.

In one of the ground floor toilets we saw the paper towel dispenser attached to the wall was not suitable for the paper towels the service was using. The paper towels had been put on the windowsill behind the toilet which meant when the toilet was flushed the paper towels could become contaminated. The clinical waste

bin had a large crack in the lid, again meaning it could not be properly cleaned. In people's bedrooms we found liquid soap was available but there were no paper towels for staff to use. This meant after delivering personal care staff could not dry their hands effectively. When we discussed this with the registered manager, they told us dispensers had been delivered two weeks ago and they were waiting to be fitted.

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

We received a mixed response when we asked people if they felt safe. Some people and their relatives told us they felt safe. One person said, 'It's a very nice place here and I feel safe." Another two people told us they felt safe. A relative said "I think mum is safe here. I'm not aware of any major concerns." Another relative said, "I feel that the care is safe here and have not had any concerns."

Other people and relatives had different opinions. One person said, "I don't really feel safe because things keep disappearing from my room. Staff aren't around much and they don't come in to have a normal conversation." Another person told us, "I'm safe up to a point, but not completely. I feel that staff don't always support me adequately. Some days there are staff here for help and some days there are not." A further person said, "I don't feel safe. I cannot sleep in here and I'm frightened. I want to go back into hospital." A relative said, "There is some room for improvement, particularly around recreational activity and supervision. Staff seem to take breaks at similar times, leaving rooms unsupervised with potential for risk."

We found there were not always sufficient staff deployed to meet people's needs. On the first day of our inspection we observed there were periods of up to 15 minutes when there were no staff present in communal areas where people were sitting. We saw people did not have call bells to hand when they were in communal areas and when we asked staff how people could summon staff assistance they were not able to answer the question. On the second day of our visit the registered manager told us the staffing levels had been increased by one care assistant throughout the day in response to concerns we had raised about one person who had experienced several falls. However, we observed there were still periods of time when no staff were present in the room where this person was sat. When we were present there were eight staff on duty for 25 people although these numbers reduced after 4.30pm and overnight. The deployment of staff as well as the numbers of staff needed to be reviewed as we observed times when lots of staff were gathered in the communal areas and other times when there were none present.

We asked the registered manager how staffing levels were calculated. The registered manager told us they assessed people's dependencies but they were not able to tell us or show us how this information was used to determine the numbers of staff required to meet people's needs.

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

We found the systems in place to manage risks to people were not always effective. We saw risk assessments were in place in people's care records for areas such as nutrition, pressure area care, falls and moving and handling. However, we found these were not always up to date or accurate. For example, we saw a falls risk assessment for one person which showed they were at high risk of falls and the risk management plan showed they had had three falls in December 2017. Our review of accident reports and the person's daily records showed they had fallen eight times since December 2017 yet the risk assessment and management plan had not been reviewed or updated. On the first day of the inspection the registered manager told us this person was constantly supervised by staff when they were out of bed, yet we observed this was not the case. We made a referral about this person to the local authority safeguarding team. When we returned on

the second day the registered manager told us the person now had a sensor mat in their chair which would alert staff when they tried to get up. However, we found this was not in place. When we discussed this with the registered manager they showed us the mat they used which was in another chair. We saw this was an enuresis mat (used for people with continence problems which alerts staff when they require support with their continence needs), which was not appropriate for falls management. When we pointed this out the registered manager acknowledged that this was not the right mat to be used. We saw the person had sustained a further fall since our first visit and the daily records showed the sensor mat in place by the person's bed had not alarmed to alert staff. One staff member told us the sensor mat did not always work and was 'temperamental'. We made a further safeguarding referral about this person.

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

The registered manager told us all staff had received safeguarding training and said they were arranging refresher training but had no dates for when this would be delivered. The training matrix showed two out of the 35 staff listed had received safeguarding training in 2016. Eighteen had not received safeguarding training since 2013 and a further eleven staff had no training dates recorded. Following the inspection the provider sent us information which showed 16 of the 18 staff who the matrix showed had received safeguarding training in 2013 had received an update in 2016. However, this meant there were still 13 staff who had not received up to date safeguarding training.

The registered manager told us there had been two safeguarding incidents since the last inspection. These had been referred to the local authority safeguarding team and notified to the Care Quality Commission. However, we saw the home had a copy of the local authority falls protocol dated August 2016 which required any unwitnessed fall resulting in an injury to be referred to safeguarding. The protocol's definition of an injury included pain, bruising, swelling and skin tears. Our review of accident and incident records showed a significant number of falls which fitted into this category, yet the registered manager confirmed none had been referred to the local authority safeguarding team. We also saw an accident report that showed one person who used the service had hit another person and this had not been referred to safeguarding either.

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

Safe recruitment procedures were in place. Staff files we reviewed showed checks had been completed before new staff started work. This included two written references and a criminal record check through the Disclosure and Barring Service [DBS]. Systems were in place to ensure nurses had valid and current registration with the Nursing and Midwifery Council (NMC). Interview notes were recorded and when all documentation had been reviewed a decision was made about employment. This meant staff were suitably checked and should be safe to work with vulnerable adults.

Inadequate

Is the service effective?

Our findings

The Mental Capacity Act 2005 [MCA] provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards [DoLS]. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager told us they had completed MCA and DoLS training, however, we found their understanding of the legislative framework was poor. The registered manager was initially unclear how many people had DoLS authorisations in place, but following discussion with the deputy manager we established there were two.

We looked at one of these DoLS authorisations which had a condition attached on 10 November 2016. The condition stated to, "Review the use of bed rails MCA assessment relating to the decision to use bed rails and a best interest meeting if (person) lacks the capacity. I am requesting that all less restrictive options are explored due to risk of entrapment." We saw bed rails were still being used for this person and there was nothing in the care records to demonstrate the best interest process had been followed. The registered manager was aware of the condition but was unable to provide us with any evidence to show it had been met. We saw entries in the care records which had been made since the DoLS authorisation had been put in place which showed the person refused to have bumpers on the bed rails and kept putting their legs over and between the rails.

The registered manager told us LPAs were in place for three people in relation to the management of their finances. We asked the registered manager for evidence of this. Documentation was provided for one person which showed the LPA was for health and welfare. No evidence was found for the other two people and nothing was recorded about LPA in the care plan we checked for one of these people. This information needs to be clear in people's care plans so if people lack capacity to make decisions at any given time staff know who has the legal authority to make decisions on their behalf.

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

People we spoke with gave mixed feedback about the food. One person said, "I like my drinks of tea here, but the food is not as good as it could be. I stay in bed and feed myself. The food is delivered when they want, not when I want." Another person said, "I get plenty of drinks here, but I don't really like the food. There isn't much choice. It seems quite a limited menu, but I can ask for more if I wanted." A further person said, "The food is good on the whole." Another person said, "The food is excellent in here."

We observed lunch on the first day of our inspection. There were six people in the dining room and others had their meals in the lounge or in their bedrooms. The atmosphere was mostly calm and pleasant. There was a pictorial menu on the wall, showing the day's choices at breakfast, lunch and tea. The tables were nicely set with vases of artificial flowers, cutlery, napkins and condiments. However, the tablecloths and placemats had a busy cupcake pattern and shiny surfaces, which we saw caused some visual confusion for one person, who was pulling at their placemat trying to find their knife, fork and spoon to eat their hot meal. The food was well presented and served. There was orange juice on the tables and we saw the care staff assisted people by coming round to pour it out, then later, to pour cups of tea from a teapot and gravy from a gravy boat over each meal, but offered no further or individual assistance with eating. The food had good colour contrast with the white crockery. We saw one person did not want the main course and asked for cheese and biscuits which were provided. We saw the person ate these happily and drank two cups of tea. We saw a staff member assisting one person who was sitting in the lounge with their meal. The staff member was patient and kind and chatted to the person asking if they were enjoying the meal and checking they were ready for another mouthful.

We met with the cook who had a good understanding of people's dietary requirements and preferences. They explained how they fortified the meals with butter, cream and milk and told us a range of snacks were available which included crisps, cakes, sandwiches and biscuits. We saw menus followed a four week rota and the cook told us there were alternatives available to the main meal.

However, we had concerns about how people's weight and nutritional needs were being monitored to ensure they were receiving sufficient to eat and drink. For example, one person's nutritional care plan stated they were to be weighed monthly, yet the last recorded weight was in September 2016 which showed they had lost 6kgs in weight over the previous three months. The care plan had not been updated since December 2016 and we found the nutritional supplements recommended by the dietician in November 2016 were not prescribed on the medicine administration record.

We saw another person's nutritional care plan dated 6 January 2017 showed they had lost weight and stated to give small meals, extra snacks, milky drinks and nutritional supplements. We saw the last recorded weight was in December 2016 when the person weighed 52kgs and had a body mass index (BMI) of 18, before that the person had been weighed in June 2016. We saw food and fluid charts for this person were poorly completed and some days showed very little intake. For example, one day's intake consisted of a bowl of porridge, a quarter of a main meal and three teaspoons of dessert and a bowl of soup, another day the only food recorded for the whole day was rice pudding. There was no evidence to show additional snacks or milky drinks had been given. Similarly fluid charts showed a total intake of 590mls on one day and 615mls the next day. There was no information to show the recommended daily fluid intake and no evidence to show the food or fluid charts had been reviewed by staff to ensure the person was receiving sufficient food and fluids. Similar concerns had been raised at the previous inspection.

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

We saw new staff completed an in-house induction however this was based on 'Skills for Care Common Induction Standards 2005' and not on the most up to date legislation. The registered manager told us new care staff without previous care experience were enrolled on the Care Certificate. The Care Certificate is a set of standards for social care and health workers launched in March 2015. It is aimed primarily at staff who do not have existing qualifications in care such as an NVQ (National Vocational Qualification).

Many staff had achieved recognised qualifications in health and social care. We discussed staff training with

the registered manager and reviewed the training matrix. The registered manager told us some training had been completed since the last inspection but recognised there were still gaps where staff had not received updates. They said they were meeting with a training provider on 1 March 2017 to arrange dates for refresher training. The training matrix identified mandatory training for staff and we found significant gaps where staff had either not received annual updates or had no training dates recorded. The majority of staff had received up to date training in the MCA and DoLs, moving and handling, infection control and first aid and we saw training had been booked for palliative care. However, only five staff had received training in fire safety, dementia care and food hygiene, three staff had received equality and diversity training and four staff had completed health and safety training.

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

Staff told us they received supervision and this was confirmed in the staff records we reviewed. The registered manager showed us an annual planner they had put in place to ensure staff received regular supervision and annual appraisals.

We asked people if they were able to access healthcare professionals. One person said, "They do call the GP if needed, but I haven't seen an optician." Another person said, "They call in the GP if needed. I think there is a visiting chiropodist every four months, but you have to pay extra for that." A further person said, "If needed, the staff will call the GP for me, but I don't have a chiropodist.' A relative said, "Staff seemed to be trained and would call for the GP, if mum needed to be seen. They usually notify me of any changes."

People's care records showed they had been seen by a range of health care professionals including GPs, community matrons, dieticians and podiatrists. However, we were concerned that healthcare advice was not always sought in a timely way. One relative told us, "It seems to take months to get any specific health problem sorted. For example, last year my (relative) had an ear infection, which we were told that the GP was called to, but nothing was followed up and although we kept reporting the problem, nothing happened. The Quest nurse wrote a prescription, but nothing came and finally (staff member) brought in a bottle of olive oil, which looked as if it had been bought at a local shop, which was applied to the ear using cotton wool, which had been soaked in oil from the tipped up bottle. It was only when the (new nurse) arrived before Christmas that things actually happened and my (relative's) ear began to heal with the correct prescription." We looked at this person's daily records which confirmed this relative's account.

Requires Improvement

Is the service caring?

Our findings

People and relatives we spoke with gave mixed feedback about the staff. These were comments made by people who used the service. "I'm not really happy here. The staff don't come anywhere near usually and they don't help much. I'm stuck in bed with this view" and "I don't really like it here. The staff are good for the most part, but there is some inconsistency".

Other people made more positive comments. "I don't think that you'd find a better place to live. The staff are kind and respectful and good at listening" and "I like it here and it's peaceful. All the staff seem very pleasant."

Relatives made the following comments. "The staff are generally kind and caring, but they tend to gather in groups. We wouldn't have been allowed to do that at work and it's not something you would expect, especially when there are so many residents to support" and "Overall they do care, but they don't really seem to know what is actually required. This is why (relative) comes in to push the fluids. My (relative) wouldn't be here if it weren't for (relative), but it's too much for (relative) to cope with and (relative's) being made ill with all this daily stress" and "There does seem to be inconsistency amongst the staff with some better than others. Some carers aren't good."

We saw staff treated people with respect and maintained their privacy and dignity. For example, we saw any personal care was carried out in private. We saw people were offered clothes protectors at mealtimes and asked if they would like a blanket over their knees when sat in chairs. We saw when people were hoisted staff made sure their clothing was adjusted to maintain their dignity. People looked clean and well groomed. This was confirmed in comments made by people when we asked if staff treated them with respect. One person said, "The staff respect my choices and bend over backwards to help." Another person said, "Staff always knock on the door before coming in." A further person told us, "Of course I'm treated with respect. Why wouldn't they?"

Although we saw people and/or their relatives had signed consent documents in the care records when we spoke with people their comments suggested they did not feel involved in planning their care. One person said, "I don't think I've been asked about my care, but the staff do change my night wear." Another person told us, "There's no real support in terms of my independence, but then I need to be hoisted now and cannot walk independently. I've had no say in my care plan here." A further person said, "I don't think I'm involved with my care plan. My daughter sees to a lot of things here for me."

Although during our inspection we observed some kind and caring staff interactions with people, we also found there was a lack of awareness and consideration about the things that mattered to people. For example, we mentioned to one visitor that their relative seemed to be having trouble hearing us. The visitor checked their relative's hearing aid and confirmed the battery was dead and replaced it. They commented, "Regular hearing aid checks should be part of my (relative's) care plan. I'm not sure how often my (relative) is bathed, but yesterday I had to mention that (my relative) seemed to need a bath. This is the one and only time that I felt this has needed to be mentioned." We checked this person's care records which confirmed

the concerns about bathing had been raised. We saw the last recorded bath for this person was on 12 January 2017.

We spoke with another person who was in bed. Their television was on but the remote control had been placed out of their reach. They asked us to switch the television off so we could talk.

We saw another person was having difficulty looking at photographs on their relative's mobile phone. We asked the relative if the person wore glasses and they said yes but they had not seen them recently. A staff member went to get the person's glasses from their room. When the person put the glasses on we saw them smile broadly as the photographs had obviously become clearer. The staff member said they had not realised the person wore glasses. When we visited on the second day the person did not have their glasses with them

One person said, "The staff don't really bother with me. They just shuttle me from place to place. I don't really like the activities here, so don't take part very often. I used to like to knit and crochet, but I can't see to do this anymore. It's the same with reading, my eyesight just isn't good enough. I would love to go out into the garden on fine days like this, but it would mean that care staff would need to help me. They're often too busy with other things to be able to do this. I used to go to church regularly, you know, and it's sad that it's no longer possible to practice my faith (Church of England) in here.'

We asked staff how people's faith needs were met and they said there used to be a vicar who visited. When we asked the activity organiser they told us, "The vicar used to come every six weeks, but he's missed the last two times as he's had flu. He's due to come again on April 17th. I thought that (person's) family would have sorted something out for her."

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

Inadequate

Is the service responsive?

Our findings

Care records we reviewed showed people's needs had been assessed before they moved into the home. Care plans and risk assessments were in place however, these varied in the amount of detail recorded. Some records were person-centred, up to date and clearly showed people's preferences. For example, one person's nutritional care plan showed they had a good appetite, enjoyed a beer and liked a cooked breakfast. In contrast other care plans did not reflect people's current needs or detail the support they required from staff. For example, one person's personal hygiene plan said 'one staff to support meeting personal hygiene'. There was no information to show what support the person required from staff or what they could do for themselves. This person's nutritional plan said the person used drinking straws, yet information in the daily records showed on discharge from hospital in January 2017 hospital staff had advised the person was not to use straws. The care plan had not been updated since December 2016. Another person's nutritional care plan stated they were to be weighed monthly and this had not been reviewed since 15 November 2016. The last recorded weight was 18 May 2016 when the person weighed 43kgs and had a body mass index (BMI) of 15 and was assessed as a being at high risk of malnutrition.

We also found discrepancies in some of the records we reviewed. For example, one person's height was recorded as 5'9" in one record and 5'5" in another. This had a bearing on the person's BMI calculation, which if the person was 5'9" put them at higher risk of malnutrition.

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

The home employed an activity organiser and we saw an activity programme was displayed in the home. This included one-to-one time as well as group activities. Photographs were displayed in the dining area and the activity organiser told us these were from Christmas time. We saw there had been visits from local schoolchildren and a choir which one person's relative sang in. There were also photographs showing Christmas Day celebrations in the home.

People gave mixed feedback about the activities provided in the home. One person said, "I get visited by my (relatives), when their work shifts allow. I don't do any activities in here." Another person said, "I like some of the activities, for example the quizzes. I tend to read a lot in my room. I'm very lonely here." A further person said, "I don't do many of the activities here, just the quizzes, but I get out every day and buy newspapers for myself and for other residents. I also like to go to town on Wednesdays. I prefer to do Sudoku puzzles and watch TV in my room."

The complaints policy was displayed in the home which defined a complaint as, "Any expression of dissatisfaction, whether justified or not." It continued with the following, "Complaints may arise through many channels including email, phone, letter or in person."

We looked at the complaints file and saw the last recorded complaint had been made in June 2013. We asked the registered manager if there had been any complaints and they told us there had been two. One of

these was about the food and the other was about a nurse not getting timely medical intervention. We asked to see the records of these complaints, however, the registered manager could not be find them.

We saw in one person's records their relative had been unhappy as no staff member had been available to go with the person when they needed hospital treatment. This had not been recorded as a complaint or dealt with in accordance with the home's own procedure. The home's accident procedure stated a staff member should always accompany a person to hospital. We discussed this with the registered manager who acknowledged neither the complaint or accident policy had been followed.

In another person's records we saw their relative had complained as they felt the person's personal hygiene needs were not being met. The registered manager acknowledged these concerns had been raised with them but had not been recorded or dealt with as a complaint.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations

Inadequate

Is the service well-led?

Our findings

Since our last inspection in July 2016 the Local Authority and Clinical Commissioning Group (CCG) had been providing ongoing support to the management team to help them make improvements to the service. However, although we found new systems and processes had been put in place our evidence showed these were not working effectively or consistently.

For example, accident and incident audits did not reflect the full extent of these events. The audit for December 2016 showed five events yet our review of the accident and incident reports showed six had occurred. Similarly the January 2017 audit listed eight events, yet our review found nine accident and incident reports and also evidence of three further incidents in one person's daily records which had not been recorded on accident/incident forms. The quarterly audit from September to December 2016 showed nine accidents and incidents had occurred in the quarter, yet we counted 13 accident and incident reports for this timeframe. This meant the recording and audit systems were not accurately capturing the level of risk and this placed people at risk of harm.

People's care records were not always accurate or up to date and did not reflect people's current needs or preferences.

We saw regular nurses meetings had been held with an external consultant. The minutes from the meeting in January 2017 had identified not all accidents and incidents were being recorded on the tracker and noted some care plans were more person-centred than others and reminded the nurses that care plans needed to be updated if risks or needs changed. We found the same issues at our inspection.

We saw weekly environmental audits had been introduced which focussed on the bedroom accommodation. We saw one had been completed on 2 February 2017 by the deputy manager and another on the 7 February 2017 by the provider. We saw one of the questions on the audit was, "Handwashing facilities in resident's own room including en-suites, evidence of wall mounted liquid soap and paper towels for care workers to decontaminate hands at the point of care." On both of these audits the box had been ticked and no issues identified. We found there were no wall mounted soap dispensers, the liquid soap was in bottles and there were no paper towels. This showed us these audits were not effective.

At our last inspection we had found problems with the water temperatures and identified a number of outlets where the water was not sufficiently warm and we found the same issue at this inspection. We also found areas in the home where the room temperature was cold. When we asked the registered manager if there were ongoing problems with the heating or water they said there had not been any problems with the heating and the issues with the water temperatures had only arisen since the weekend. However, our review of minutes from the residents' meeting in December 2016 showed people who used the service had complained of feeling cold at night and had requested more blankets, which showed there had been problems over two months ago.

Weekly medicines audits were completed and although we saw these had identified issues which had been

addressed, the shortfalls we found at this inspection had not been picked up or rectified.

There was no collective monitoring of people's weights and where people's food and fluid intake was being monitored, there was no regular oversight of this to determine whether people had consumed enough food or fluids. This had been identified as an issue at the previous inspection.

We saw the registered manager and deputy manager were visible in the home and worked alongside the staff. Staff told us they felt supported by the management team. Some people we spoke with knew who the registered manager was and spoke positively about her. One person said, "I would always go to (registered manager) with any concerns." Another person told us, "The manager is very approachable." A relative said, "I feel that I can approach the manager about any aspect of my mum's care."

However, other people expressed a different view. One person said, "The manager here just does not listen. It's pointless talking to her." Another person said, "I don't think I know the manager here." A further person said, "I didn't realise that (name) was the manager." A relative said, "I do not know who the manager is here. I haven't met her."

We found the regulatory breaches identified at our previous inspection had not been met and found additional breaches, which demonstrated a lack of effective leadership and governance.

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