Calderdale Metropolitan Borough Council

Ferney Lee Services for Older People

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 13 January 2016 and was unannounced. At the last inspection on 27 May 2014 we found there was one regulatory breach which related to the safety and suitability of the premises.

Ferney Lee provides accommodation and personal care for up to 31 older people, some of who are living with dementia. Accommodation is provided in single bedrooms over two floors. Ferney Lee offers a mixture of placements which includes permanent places, intermediate care, transitional, emergency and respite care. There were 30 people using the service when we visited. This included nine people who lived there permanently, ten people receiving respite care, five emergency placements and four transitional placements. Accommodation is provided over two floors and the intermediate care is provided on a separate unit. There are communal areas throughout the home including lounges, dining rooms, a large central kitchen and separate smaller kitchens.

The home does not have a registered manager. The registered manager left in December 2014. A new manager was appointed who is intending to register with the Commission. This manager was present when we carried out the inspection. 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.

Although people told us they felt safe in the home we found risks to people were not always well managed. For example, equipment identified as needed to keep one person safe and to reduce the risk of falls was not being used. Safeguarding incidents were not always recognised by staff or reported to the local safeguarding team which placed people at risk of harm.

People told us they received their medicines when they needed them yet we found staff were not acting in accordance with the medicine policy which meant medicines were not always managed safely.

People and staff told us the home had been short staffed over Christmas. We saw staffing had improved recently with an influx of staff from another service which ensured people's needs were being met. We saw some documentation which showed recruitment checks had been completed, however application forms, references and interview records were not seen and although the provider agreed to forward these to us after the inspection they were not received.

At the last inspection we had identified concerns in relation to the premises. We found improvements had been made at this visit and the premises were well maintained.

There was a stable staff team and many of the staff had worked in the home for many years and as a result knew people's needs well. However, we found some gaps in the training matrix which meant we could not be assured all staff had received the training they needed. We also found care records varied. Those we saw

on the intermediate care unit were detailed and up to date, yet other people's care plans and risk assessments had not been updated or reviewed for three months and some people had no care plans. This placed people at risk of receiving unsafe or inappropriate care.

We found staff and the manager lacked understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). We found an accumulation of restrictions indicated some people who lacked capacity may require a DoLS application, yet none had been made.

People said they enjoyed the food and we found mealtimes were a pleasant experience and staff gave people support and encouragement to ensure a good dietary intake. We found people had access to health care services such as GPs, chiropody and optical services. People told us they knew how to make a complaint and would speak with staff if they had any concerns.

People and relatives praised the staff and the care that was given. People described how staff treated them with respect, promoted their independence and were kind and considerate in all their interactions. Staff had embraced the learning they had gained from training in Dementia Care Matters and spoke enthusiastically about changes which had been introduced as part of the Butterfly Project which embraces person-centred care for people living with dementia. We saw the benefits this had brought to some people such as the use of doll therapy to bring comfort and contentment to two people.
There was no organised activity programme, though we saw activities taking place. Most people told us they were satisfied with the activities provided although two people felt there could be more going on.

Staff told us the manager was supportive and worked with them to make improvements. The manager told us they had struggled over the Christmas period as they had been without administrative support which had impacted on their work. We found there had been lapses in the quality assurance systems over the last nine months which meant issues we identified at this inspection had not been picked up or addressed by the provider. Providers are required by law to inform us of certain events that occur in the care service. We found notifications had not been made on three occasions when they should have been.

We identified six breaches in regulations – regulation 18 (staffing), regulation 12 (safe care and treatment), regulation 13 (safeguarding), regulation 11 (consent), regulation 9 (person-centred care) and regulation 17 (good governance).

The overall rating for this service is 'Inadequate' and the service is therefore 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.

Medicines management was not safe as staff were not always following the medicine policy which meant people were at risk of not receiving their medicines when they needed them.

Risks to people's health, safety and welfare were not properly assessed and mitigated. Safeguarding incidents were not always recognised or reported.

There were sufficient staff to ensure people's needs were met. We were not provided with full documentary evidence to show that robust staff recruitment processes had been followed.

Systems in place ensured the premises were well maintained.

Is the service effective?

Inadequate

The service was not effective.

Staff had a good understanding of people's needs, yet gaps in the training records meant we could not confirm all staff had received the training they required. Supervision and appraisals had taken place but the regularity of these had declined in the past year.

Staff lacked understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Accumulated restrictions we found suggested DoLS applications should be made for some people.

People said they enjoyed the food and were offered a choice. However, people's nutritional needs were not monitored effectively and one person was not receiving the special diet they required.

People's care records showed they received input from a range of healthcare professionals.

Is the service caring?

Good

The service was caring.

People gave very positive feedback about the staff. We saw staff were kind and caring and patient with people.
People's privacy and dignity was maintained and staff treated everyone with respect.

People were supported by staff to maintain their independence

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not up to date and, in some cases, were missing which put people at risk of unsafe or inappropriate care

Some activities were taking place, although there was no structured programme.

People knew how to raise complaints and had confidence they would be dealt with.

Is the service well-led?

Inadequate

The service was not well led.

There was no registered manager, although a new manager was in the process of registering and staff said they were supportive.

The provider had not notified the Commission of events which they were required to do by law.

Quality assurance processes had lapsed which meant issues we identified at this inspection had not been identified or addressed by the provider.

Ferney Lee Services for Older People

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 13 January 2016 and was unannounced. Two inspectors attended and an expert by experience with experience of older people's services. 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 commissioners and the safeguarding team.

We usually send the provider a Provider Information Return (PIR) before the inspection. 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. We did not send a PIR on this occasion.

We spoke with eight people who were using the service, three relatives, three care staff, a team leader, a kitchen assistant, the chef, the residential team leader, the manager, and the operations manager.

We looked at six people's care records, five 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, bathrooms and communal areas.

Inadequate

Is the service safe?

Our findings

We found variable practice in how risks were managed. Some people required help with their mobility and we saw staff made transfers safely. We observed one person being assisted to move who was very anxious and staff constantly reassured them. The two staff checked they had the correct equipment and stayed with the person every step of the way directing and encouraging them. However, we found other risks to people were not always managed safely or appropriately. Although risk assessments and management plans were in place to keep people safe these were not always being followed. For example, we saw one person's risk assessment showed they were prone to falls and required a sensor mat next to their bed and chair. Sensor mats are devices which are linked to the call bell system and are activated when pressure is applied so staff are alerted. We saw this person in the lounge and there was no sensor mat by their chair. We looked in their bedroom and found no sensor mat. When we asked staff about this they told us the person required a sensor mat but the ones they had were broken and there were not any spare ones which they could use. The care records showed this person had been without their sensor mats for six days and had sustained a further fall during this time. This person's records documented twenty falls between 28 December 2015 and 8 January 2016, yet the falls risk assessment had not been reviewed since 3 December 2015. We looked at the care records of a person who had been in the home for a short stay in December 2015. They had been assessed as being at risk of harm through absconding. The risk assessments recommended a sensor mat should be placed by the person's bed to alert staff thereby reducing the risk of absconding and the inherent dangers of being out in the community. Records showed the person left the home without the staff's knowledge on five occasions in three days before the sensor mat was put in place. This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although staff told us they had received safeguarding training, staff we spoke with had a lack of understanding and knowledge of safeguarding and what constituted abuse. This was also evident from the records we reviewed which showed incidents which were clearly safeguarding matters had not been referred to the local authority safeguarding team or notified to the Commission. We found there had been a failure to safeguard people from the behaviour of people who lacked capacity, and were unaware of the impact of their actions, which resulted in people being abused. For example, staff told us one person regularly used language which upset other people who lived in the home. They told us four people went to their rooms to get away when the person was using this language. We saw entries in the daily notes which showed people were 'very agitated' and 'upset' by this behaviour. Yet when we asked care staff, including senior staff, if this was verbal abuse they said they thought it was but had not followed safeguarding procedures by reporting this to the local authority safeguarding team. Records showed there had been one occasion when this person had smacked another person on the arm. This had not been referred to safeguarding. We made a referral to the safeguarding team as we considered people were at risk. This was a breach of the Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the provider's medicines policy, which complied with current legislation and best practice in the administration of medicines. Although people told us they received their medicines when they needed them and we saw medicines were stored safely and securely, we found systems and processes in place to manage medicines were not always safe or effective.

During the morning we observed a staff member administering medicines and asked them how they ensured people received the correct medicines. Answers given and our observations demonstrated medicines were not consistently administered in a competent manner. For example on four occasions we witnessed the staff member handling medicines without gloves. On another occasion we witnessed controlled medicines being administered. Whilst a colleague checked the controlled medicine stock levels they did not witness the medicine being administered. This contravened the provider's own policy.

We saw the staff member administering medicines in a manner which did not comply with the prescriber's instructions. For example, the dosage of one medicine was written incorrectly on the medicine administration record (MAR) as it did not tally with the prescription label on the medicine box. We saw the staff member administered this medicine yet did not query this discrepancy. The label on the box clearly stated the medicine should be administered before food yet it was given after food. When we raised these issues with the staff member they said, "I have not seen that before", which showed the medicine had not been properly checked before administration. We witnessed another medicine being administrated after food despite the written instructions stating to administer before food.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs. We observed the oral administration of a controlled drug which was recorded as a handwritten entry on the MAR but there were no signatures to show when it had been administered. The staff member told us they only recorded this in the controlled drug register. The provider's policy states the recording of receipt, administration and disposal of controlled drugs should be recorded on the MAR.

We found protocols were not in place to guide staff as to when and how often to administer 'as required' medicines. For example, one person was prescribed a medicine to control the amount of urine passed. The instructions on the medicine label read "at bedtime when required". We asked the staff member why the medicine was prescribed and what it was for, they did not know and said, "I have never come across this drug before". This demonstrated in the absence of protocols people may not be receiving medicines as the prescriber had intended.

We checked the stock levels of 12 medicines and on 10 occasions found discrepancies. On five occasions the stock levels counted did not tally with the number of medicines received on the administration record. For example, one person was prescribed a medicine to be taken twice a day. The MAR showed 29 tablets in stock when the MAR had started, nine tablets were signed for yet 21 tablets remained, indicating one tablet had been signed for but not administered.
Another person had a box of pain relief tablets, one tablet was absent from the dispensed total of 28. Yet the person's MAR did not include this pain relief medicine therefore we could not reconcile how one tablet had been administered nor could we be assured the person was being offered analgesia as the prescriber intended. This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in May 2014 we found a regulatory breach relating to the safety and suitability of the premises as we identified maintenance works were needed to the building. At this inspection we found improvements had been made. We looked round the building with the operations manager. We saw six people's bedrooms, bath and shower rooms and various communal living spaces, the kitchen and the laundry. The laundry door was unlocked with cleaning products on working surfaces freely accessible to people. The operations manager told us the door was usually locked.

All radiators in the home were covered to protect vulnerable people from the risk of injury. We saw fire-

fighting equipment was available and emergency lighting was in place. All fire escapes were kept clear of obstructions. We saw upstairs windows all had restrictors fitted to limit the opening. All floor coverings were of good quality and with one exception were free of trip hazards. We found one small area of corridor carpet was posing a trip hazard due to a recent ingress of water. The operations manager provided assurance that this was being addressed. Hot taps were fitted with thermostatic control valves to protect people from harm caused by hot water. Records showed hot water temperatures were regularly checked and within permitted ranges. We reviewed environmental risk assessments, fire safety records and maintenance certificates for the premises and found them to be compliant and within date.

People told us they felt safe in the home. One person said, "Some of the other residents are a bit noisy and more demanding but I feel safe." Another person said, "They've been short staffed but I feel safe." The manager told us the usual staffing levels during the day were a team leader and seven care staff between 8am and 3pm and a team leader and four care staff between 3pm and 10pm. At night there were three care staff from 10pm to 8am. Staff we spoke with told us they had been short staffed on several occasions over the Christmas period. The manager confirmed this but said the occupancy had been lower and told us staff had worked extra hours to provide cover when necessary. On the day of the inspection we observed there were sufficient staff to meet people's needs. We met staff who had been transferred from one of the Council's other services which was closed due to the floods which had occurred after Christmas. Staff from Ferney Lee told us this increased support had made a big difference and ensured they could deliver the individualised care promoted through the Dementia Care Matters Butterfly Project.

Staff recruitment files we reviewed showed checks such as proof of identity and satisfactory outcomes of Disclosure and Barring Service (DBS) were carried out before staff began work. These checks helped the service to make sure job applicants were suitable to work with vulnerable people. We saw the manager had secured identification in the form of either a driving licence or passport. There was no evidence of application forms, references or interview records in the files and the operations manager told us these were kept at the Council offices. They said they would send these documents through to us, but these have not been received.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

There were no DoLS authorisations in place and only one application had been made although this person was no longer at the home. However our observations of the environment and people's care plans suggested the provider utilised a number of methods which may constitute a deprivation of liberty. The front door was locked. Some people had sensor mats at the side of their beds to alert staff if the person was vacating their bed. Records showed another person had a sensor mat in operation during the day placed in an open doorway to alert staff if the person vacated their room. Whilst we could find no evidence of specific mental capacity assessments some care plans recorded diagnoses and other indications of reduced mental capacity. All were for their safety being supervised and others were assessed for their safety to need two hourly observations during the night. We asked the manager if they would prevent or try to persuade certain named people from leaving the home. The manager said they would. Whilst each element of restrictions may not constitute a deprivation of liberty, it may be the case that the accumulation of restrictions being experienced by some people lacking in mental capacity may amount to an unauthorised deprivation of their liberty. We judged the provider may be exercising control over people's care and movements. The manager told us they would carry out assessments based on our observations and make applications if necessary.

The MCA 2005 allows in certain circumstances restrictions and restraint to be used in a person's support but we found the manager did not have a sufficient understanding of the MCA and in particular DoLS to be able to discharge this duty effectively. Our discussions with the operations manager and manager showed they did not know that they as the managing authority could deprive someone of their liberty for up to seven days using an urgent authorisation, submitting a standard authorisation at the same time. This was a breach of the Regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person was receiving their medicines covertly, yet when we reviewed the care records for this person there was no legal framework in place which would allow medicines to be administered covertly. Whilst we saw a GP had stated they wished for medicines to be administered covertly to ensure good health was maintained we saw no other evidence to demonstrate the MCA 2005 was being complied with. Furthermore national guidance, (Managing medicines in care homes - National Institute for Health and Care Excellence (NICE) guidelines March 2014) was not being adhered to and the provider's own medicines policy which complied with the MCA 2005 was not being followed. There was no evidence of a best interest meeting, no evidence of a pharmacist's advice, no treatment plan, no instruction as to how to disguise the tablets and

no plans to review the practice. This was a breach of the Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at five staff records to gauge the uptake of training opportunities, initial induction for new starters, supervision meetings and yearly appraisals. Records showed although staff had started an induction programme this had not been progressed. We saw within the last year staff had attended training in areas such as, infection prevention and control, first aid, safeguarding, food hygiene and dementia awareness. However, we noted refresher training was due in some areas. We looked at the training matrix and found significant gaps which showed refresher training was overdue for some staff and for others there were no training dates. Following the inspection the manager sent us an updated training matrix. Although this provided information to show updates had been delivered there were still gaps where there were no training dates for some staff. For example, there were no training dates for three staff in manual handling, two staff in relation to infection control and 22 staff in relation to safeguarding adults. We saw the impact of this lack of training as safeguarding incident had not been identified or acted upon by staff which place people at risk of harm or injury. This was a breach of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed staff had received regular supervision in recent years but this had declined in regularity during 2015. For example, records we accessed back to 2009 showed supervision meetings four or more times a year; by 2015 the frequency had reduced to twice a year. We saw staff had received an appraisal in April 2014 but no evidence of any appraisals since. The manager and operations manager acknowledged these had slipped due to management changes over the past year.

However, we found all staff had received training in the Butterfly Project as part of the Dementia Care Matters programme. The Butterfly Project is a model of dementia care for care homes supporting people living with dementia. Staff we met with spoke enthusiastically about this training. They told us it had made them think about how they supported people and the changes they had made to make care more person-centred. One staff member said, "I've seen changes in people since we started doing this (Butterfly Project). We step into their world and it makes such a difference." They then described an interaction they'd had with a person that morning which had had a calming effect on the person. The staff member said, "I wouldn't have done that before doing the Butterfly (project)." Staff no longer wore uniforms and changes had been made to the environment which included smaller seating areas and different storage systems where people could find things of interest to touch and hold. We saw staff sat and had their meals with people at lunchtime. Staff told us progress with the project had lapsed over Christmas due to staff shortages but was now starting back up again. We saw action plans were in place to ensure this happened.

People told us they enjoyed the food. One person said, "The food is very good. I haven't disliked anything. I'm a pudding girl. You do get a choice." Another person said, "The food's alright (thumbs up gesture). If I didn't like it I'd send it back. We get a choice and there's enough." A further person said, "The food's fantastic. They come round and say what do you want." One person who was vegetarian told us, "They cater for that. It's nice."

We observed lunch in the dining room and found the atmosphere was very pleasant. There was a buzz of conversation and background music. There was a choice of food and staff were aware of people's likes and dislikes. Staff told us said they were planning to take photographs of the food to show people to help them make their choice. They said this had been planned before Christmas but staffing pressures had meant it was yet to be achieved. The manager told us they were planning to change the way meals were served so people could choose their own portion size. We saw some people had smaller portions and people were asked if they would like their food cut up for them. Staff gave a lot of encouragement and helped those who

were unable to feed themselves. One staff member who was on their lunch break came and sat at a table where they had previously been helping and asked people if they minded if they joined them.

We spoke with the chef and saw menus were devised on a four week rota with two choices of a main course and dessert at lunch and tea time. There was a wide choice for breakfast including cereals, porridge, toast and a variety of cooked options such as bacon and egg. The chef told us cakes, biscuits and snacks were available throughout the day.

The chef and kitchen assistant told us no one was on a special diet. Yet we saw one person's care records showed they required a high potassium diet and provided a list of the type of foods which would be suitable. When we asked the kitchen staff about this they said they had no knowledge the person required this diet. We asked one of the care staff and a senior staff member who said the person had been taken off this diet as they did not need it anymore. When we asked who had made this decision they said one of the senior care staff. We raised this with the manager and operations manager who were not aware of this matter. Following the inspection the manager told us they had referred this to the relevant healthcare professional and had asked for bloods to be taken to ascertain if the potassium rich diet was still required for this person. We saw food charts were recorded for this person but inconsistently and with no evidence to show that the information had been reviewed to ensure they were receiving sufficient to eat. For example, the nutritional care plan dated 30 March 2015 stated the person had lost weight, was on a food chart and was to be weighed weekly. Monthly reviews showed no changes to the care plan. The weight chart showed the person had last been weighed in September 2015 and had refused on three occasions in October 2015. There were no food charts recorded for one day in December 2015 and six days in January 2016. The charts that were completed showed very little input on some days. For example, on 28 December 2015 the only food recorded was two mouthfuls of fish fingers, beans and roulade. This was a breach of the Regulation 12 (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care records showed they had access to healthcare services and we saw records of visits from GPs, district nurses, the optician and chiropodist. People who were receiving intermediate and transitional care were supported by a team of healthcare professionals such as nurses, physiotherapist and occupational therapists, who worked alongside the care staff at Ferney Lee to rehabilitate people

Good

Is the service caring?

Our findings

People and relatives we spoke with were pleased with the caring nature of the staff at Ferney Lee. One person said, "Staff are very good. I had to wait for help in hospital but here they come straight away. I can't speak highly enough of them." Another person said, "They are very, very kind. Nothing seems too much trouble….they do as much as they can for you." A further person said, "It's fine. Friendly. They care for everything you want. The staff give you everything you want."

One relative said, "This is further away than our nearest home. We'd sooner travel 30 miles than go to the one two minutes down the road." Another relative said, "We've been happy ever since she's been here." A further person said, "It's lovely – they're looking after him well. He's happy."

We observed staff were patient and kind and interacted very positively with people. Everyone was addressed by name, staff bent down to talk to people at eye level and there was some gentle and appropriate physical contact. At mealtimes we saw where people had small appetites they were congratulated in a very pleasant way. For example, one person had cleared their plate and a staff member said, "Well done you!" We saw staff gave people reassurance. For example, one person had just returned to the home and had ordered some soup. The staff member told them the soup was on its way and the person said to the staff member not to worry about them. The staff member replied, "It's my job to worry about you."

We saw staff knew people well and used that knowledge to benefit people. For example, one person in the lounge was very restless and kept trying to stand up. Staff were aware this person was at risk of falling. Another person came to sit in the same lounge and with staff encouragement the two struck up a conversation and the person who was restless became more settled.

We saw how doll therapy was used to good effect with one person. We saw this person nursed a doll all the time. Staff told us they had noticed when the person had picked up a teddy bear and were able to cuddle this they were calmer. Staff had given the person a baby doll and this had the same effect. Although the person's relative had questioned this initially they were now totally supportive and brought clothes in for the doll. We saw the person was calm and every time anyone asked her about the doll she gave a lovely smile and hugged the doll closer. Staff were very supportive and we saw when the person had tried to feed the doll from her coffee cup, coffee had spilt on the doll's clothes and staff provided a clean outfit for her to dress the doll.

Another person told us they had been able to move to a larger room so they could accommodate all the things they had brought from their own home. Amongst these were many soft toys and a doll in a pram which the person was very proud of. Staff clearly responded to the person's affection and had given them soft toys for the doll. Staff recognised the importance of these things to people and treated them with respect and in a way that preserved their dignity.

We saw people's independence was promoted and staff patiently supported people to do things for themselves in their own time. One person said, "I do as much as I can for myself. They'll help if I ask…. They

respect my privacy and ask if it's alright to do whatever." Another person said, "It's brilliant. I only ask for something when I need it…….I get embarrassed for what I can't do. I had to go upstairs because I was embarrassed. The carer took me upstairs and said not to be embarrassed and ask for what I want and if they can do it they will."

One person was delighted by the way staff had responded when they needed to go to the health centre for a hearing test and the transport arranged had failed to materialise. They told us how a staff member had taken them and said, "(Name of staff member) is lovely – they took me all the way to Todmorden for my hearing test in a wheelchair and back. They did it again when I got the hearing aids."

Requires Improvement

Is the service responsive?

Our findings

People told us they were happy with the care they received and felt their needs were met. Our discussions with staff showed they knew people well and many of the staff team had worked in the home for many years. People told us staff responded to their needs and provided individualised care. One person said, "They give me a shower once a week when I ask. I have a bed bath every night." Another person told us they had a lot of pain in their neck at night and needed a lot of pillows and said, "They (the staff) pile them up. They know what I like." A further person was very appreciative about the fact they were able to keep to a routine that suited them and said, "I stay up until I'm ready. I get up when I like. They come and ask you…… They let me stay up as long as I like. I go into the smoking room and read the paper. They ask me if I want a cup of tea. I can take one up to bed if I want."

However, we found a wide variation in people's care records which meant people were at risk of receiving inconsistent care and support. Care records for people on the intermediate care unit were well completed, with up to date risk assessments and care plans detailing the support required to meet the person's rehabilitation programme. Yet other care records we reviewed contained minimal information and did not reflect people's current needs or detail the support they required from staff. For example, there were no care plans in place for one person who was living with dementia, had complex health care needs and had been in the home for over a month. Assessment information had been provided by the social worker which outlined the person's needs. Risk assessments were recorded for falls and moving and handling but there were no care plans to show what support this person required from staff or how that support should be delivered to meet their needs. We asked a senior staff member when care plans were completed and they told us they had to be in place 24 hours after admission. We looked at the care records for another person who had been in the home 11 days. There were no care plans or risk assessments in place. There was a support plan from Calderdale Council dated 20 October 2015 but this related to care to be provided via a domiciliary care service.

We reviewed the care records of people who lived at the home permanently. Although there were care plans in place these were undated and unsigned. We found they were not person-centred and lacked detail. One person's records showed care plan reviews were recorded in July, September and October 2015 but none since. A change in the person's continence products was noted in the October review yet the care plan had not been updated. Three other care plans showed no care planning reviews had taken place in the last two months. Staff we spoke to said, "You will not find any care plans being reviewed because we have insufficient staff to do so".
This was a breach of the Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw activities taking place during our inspection and staff spent time with people individually. The manager told us there was no organised activities programme. We saw some people were given books they enjoyed. For example, one person had a book about Elvis and we saw staff talked to them about it as they went by and did some singing too. There were also boxes in the lounges containing stimulating materials and soft toys.

When we asked people about activities there was a varied reaction. One person told us they had been out on a number of occasions with a staff member to a recording of the Jeremy Kyle show and to a pub. They said they had enjoyed these outings but said they had not happened for a while as the staff member was off work. Another person said, "I'm happy. I sit with other residents – we talk about what we want to watch (on TV) so no one's offended. A further person said, "I have plenty of activities of my own to keep me busy." One person was less content and said there was one thing they felt unhappy about and would like "….more activity, perhaps a singalong. But no quizzes."

The manager told us people admitted to the service received a leaflet about the Council's complaints procedure. The manager said there had been no complaints received since our last inspection. People we spoke with raised no concerns and said if they had any worries they would speak to staff about them. One person said, "If I was unhappy I'd complain to one of the charge hands." Another person said, "Not happy? I'd just talk to one of the carers who'd pass it on to the managers." A relative said, "If I had a problem I'd report it to the staff. They're very open, very friendly, we've never had an issue."

Inadequate

Is the service well-led?

Our findings

The home has had no registered manager since December 2014. The manager who was present at this inspection had started at the home in September 2015 and was appointed as manager in November 2015. They told us they were in the process of applying for registration with the Commission.

Staff we spoke with described the manager as supportive and felt they worked with staff to make improvements for people who used the service. We observed a warm, friendly atmosphere within the home and saw people and staff got on well together and there was laughter and positive interactions between them. Although we received positive feedback from people and relatives about the care they received we found systems and processes in place to ensure people received safe and appropriate care were not always being followed. For example, as detailed in other sections of this report we found shortfalls in the way medicines and risks were managed, safeguarding incidents were not always identified or reported, care records were not up-to-date or accurate, there were gaps in staff training and there was a lack of understanding about the MCA and DoLS.

We saw minutes from a staff meeting held in October 2015. Staff told us meetings were held regularly and they were able to raise any issues. We saw residents meetings had been held in September and November 2015.

We found the provider had not submitted all required notifications to the Commission. We found a deprivation of liberty safeguards authorisation had been applied for and granted in December 2015 yet we had not been notified of this. Records showed two incidents where the police had been involved in December 2015. Although we were satisfied that appropriate action was taken to keep people safe, these incidents had not been reported to the Commission which is a legal requirement. This meant we did not have accurate information on the number of incidents which occurred in the service. We discussed with the manager and operations manager the need to ensure all notifications were reported to us in the future.

There were quality assurance systems in place but many of these had lapsed and the manager struggled to find information we requested. For example, we asked the manager for any quality audits that had been completed since the last inspection. We were shown an infection control audit dated 9 February 2015 where the home had been rated at 95.66% and a copy of an audit completed by the previous manager in March 2015. The manager told us they could not find any others and said they had not completed any audits since they started in post. We asked to see medicine audits but these were not provided. We found the service was disorganised but recognised the manager was trying to address this and had been hampered in progress due to the absence of the home's administrator which meant the manager had been covering these tasks as well as their own.

We saw quality audits of the service had been carried out by the operations manager in April, July and October 2015. However we found issues identified in the July audit had not been rectified by the October audit. For example, it was noted in July 2015 that staff were not using the audit system for monitoring stock control in the kitchen and this was still the case at the October audit yet there was no action plan in place to

show how this was being addressed.

We found accidents and incident reports were not being reviewed or monitored by managers. We saw there were systems in place to audit accident and incidents on a monthly basis but these had not been completed since July 2015, which was confirmed by the manager

We asked the manager and operations manager how staffing levels were calculated. The operations manager told us there was no tool used to calculate the staffing levels. They said people's dependencies were taken into consideration but acknowledged there were no records to evidence this. This was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users was not appropriate and did not meet their needs or reflect their preferences. Regulation 9 (1) (a) (b) (c) (3) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person had not ensured that they had obtained the consent of the relevant person to care and treatment, and where the service user was 16 or over and was unable to give such consent because they lacked capacity to do so, had not acted in accordance with the Mental Capacity Act 2005. Regulation 11 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received appropriate support, training, professional development to enable them to carry out the duties they were employed to perform. Regulation 18 (1) (2) (a).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Service users were not provided with care and treatment in a safe way in relation to assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks and in relation to the proper and safe management of medicines. Regulation 12 (1) (2) (a) (b) (g)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected from abuse and improper treatment as systems and processes were not established and operated effectively to investigate any allegation or evidence of abuse. Regulation 13 (2) (3) & (5).

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established or operated effectively to assess, monitor and improve the quality of the services provided or to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Regulation 17 (1) (2) (a) (b)

The enforcement action we took: