Chestnut Care Limited

Savile House

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

Summary of findings

Overall summary

This inspection took place on 4 and 5 October 2017. The first day was unannounced. At the previous two inspections in November 2016 and April 2017 we rated the service as 'Inadequate' and in 'Special Measures'. At our inspection on 11 April 2017 we found eight regulatory breaches which related to staffing, safe care and treatment, dignity and respect, person-centred care, consent, recruitment, good governance and failure to display a rating. 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.

Savile House provides personal care for up to 24 older people, some of who may be living with dementia. There were 16 people using the service when we visited. Accommodation is provided on three floors, there are single and shared rooms and some have en-suite facilities. There are communal areas on the ground floor, including a lounge, dining room and conservatory.

The registered manager left in February 2017. One of the senior staff had recently been appointed as the manager and had been in post for a month at the time of our inspection. The provider told us this person would be applying for registration with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The staffing levels remained the same as they had been at our last inspection in April 2017 when 18 people had been using the service. However, we found there were still times when there were not enough staff to meet people's needs, particularly at night and weekends. Staff induction was not thorough as it did not ensure staff had the competencies and skills required to complete their roles. Similarly there were significant gaps in staff training and supervision which meant we could not be assured staff had received the training, updates and support they required.

Staff recruitment had improved and we found appropriate checks had been completed before new staff started work.

Medicines were stored safely and appropriately. However, we found a lack of consistency in the way medicines were managed which meant we could not be assured people were receiving their medicines as prescribed or when they needed them.

Individual and environmental risks were not always well managed which placed people at risk of harm or injury.

Staff understood safeguarding procedures and some incidents had been referred to the local authority safeguarding team. However, we found other incidents had not as they had not been recognised as

potential abuse. Following the inspection we made a referral to the local authority safeguarding team.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible.

People had access to healthcare services such as GPs, district nurses and chiropodist.

A new electronic care documentation system was being put in place, however this was not operational at the time of our inspection and staff were working from paper care records. We found these were not always up-to-date or accurate which placed people at risk of receiving inconsistent and inappropriate care.

People told us they enjoyed the meals and we observed the lunch time meal was a sociable occasion. Daily activities were provided by the care staff and we saw people enjoying a quiz and a game of skittles. People told us the staff were kind and caring. Overall, people's privacy and dignity was respected however we found two instances where this was not the case.

People told us they knew how to make a complaint and the complaints procedure was displayed. No complaints had been received since the inspection in April 2017.

People, relatives and staff spoke positively about the new manager and felt the home was improving. However, we found the provider had made limited progress in addressing the issues we identified at our inspection in April 2017, which demonstrated governance systems were not robust or effective. This was evidenced by the continued breaches we found at this inspection.

We found shortfalls in the care and service provided to people. We identified seven breaches in regulations; staffing, safe care and treatment, person-centred care, consent, safeguarding, good governance and notification of incidents. 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 therefore 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.

Medicines management was not safe and effective, which meant we could not be assured people received their medicines as prescribed.

Staffing levels were insufficient to meet people's needs in a timely manner. Staff recruitment processes were robust.

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

Is the service effective?

Inadequate

The service was not effective.

Staff had not always received the induction, 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 staff supported people in accessing a range of health professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us most of the staff were kind and caring. However our observations showed people's privacy, dignity and rights were not always respected and maintained by staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

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

In-house activities were provided and we saw people participating in these.

Systems were in place to record, investigate and respond to complaints.

Is the service well-led?

Inadequate

The service was not well-led.

Leadership and management of the service was not consistent or effective.

Quality assurance systems were not effective in assessing, monitoring and improving the quality of the service and we found regulatory breaches identified at previous inspections had not been met.

Savile House

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 4 and 5 October 2017. The first day was unannounced and two inspectors and an expert by experience with experience of services for older people attended. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day was announced and two inspectors attended.

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.

We did not ask the provider to complete a Provider Information Return (PIR) before this 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 observed how care and support was provided to people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with five people who were living at the home, two relatives, four care staff, the chef, the manager and the registered provider.

We looked at eight people's care records, four 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 previous two inspections we found medicines were not managed safely or effectively. At this inspection, although there had been some improvements, we found issues remained.

We looked at a sample of medicine administration records (MARs) and these were generally well completed with no gaps. However, we found discrepancies in the information recorded on the MARs which could potentially result in people not receiving their medicines as prescribed. For example, two people had GP letters with their MARs which stated some of their medicines were to be crushed. However, there were no instructions on or with the MAR to identify these medicines or how they should be crushed or administered, such as all together or separately. When we asked the registered manager about this they told us one person no longer had their medicines crushed and this needed to be reviewed. They said they did not know how they were supposed to crush or administer the other person's medicines and they would check with the pharmacist. This was the same issue we had found at the previous inspection.

One person's MAR had printed instructions which stated one medicine was to be given at night. This had been crossed out and a handwritten entry stated, 'when required by Quest 14/2/17'. The manager told us the pharmacist had not printed the correct information on the MAR as the medicine was prescribed 'as required'. However, when we checked the most recent prescription issued by the GP we saw the medicine was prescribed to be given every night. This showed the systems in place for checking medicines were not robust. We also found a handwritten entry on this person's MAR which showed they were prescribed a suppository to be given 'as required'. One of the home's staff had signed to show this had been administered. However, when we checked with the manager we found the suppository had been administered by the district nurse. The manager agreed the instruction on the MAR was not clear and could not explain why the staff member had signed the MAR when they had not administered the medicine.

We saw some people were prescribed 'as required' medicines. There were protocols in place for some of these medicines but not all. This was the same situation we had found at the previous inspection. One person was prescribed a medicine to ease anxiety. There was no protocol in place to guide staff as to when this medicine should be given. Three other people had no PRN protocols in place for their 'as required' medicines. The manager told us they were putting these in place and later on the first day showed us protocols they had written that day.

We found where people were prescribed topical creams the MARs did not provide information about where the creams was to be applied. The manager told us they were in the process of addressing this with the pharmacist. We saw one person's MAR had been signed by a senior staff member to show the cream had been applied however the manager confirmed it was the care staff who applied the cream, not the senior staff member.

A medicine training session took place on the first day of our inspection. However, we found senior staff who were administering medicines had not always received up to date medicines training or had their competency assessed. For example, the training matrix showed one senior staff member had not received

medicine training since 2015. The provider told us this staff member had completed a medicine competency assessment but was unable to provide any documentary evidence of this. We asked the provider if competency assessments had been completed for three other senior staff and they confirmed they had not. They said these would now be carried out. We saw one of these staff members undergoing a competency assessment on the second day of our inspection. We concluded the management of medicines was not safe. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they received their medicines when they needed them. One person said, "The carers give me my tablets." Another said, "The staff do this. I get them pretty much on time." We found medicines were stored safely and securely. Some prescription medicines contain drugs controlled under the misuse of drugs legislation. These medicines are called controlled drugs (CD). We checked the recording and stock balance of CDs and these were correct. The provider's medicines policy had been updated in August 2017 and was displayed in the treatment room. This included guidance about covert and crushed medicines, however our evidence showed this was not being followed.

At our previous two inspections we found there were not enough staff on duty to meet people's needs. At this inspection, we had a mixed response from people about staffing levels. One person said, "There is definitely not enough staff. You can wait for anything up to half an hour before anyone [staff] takes you to the toilet." Another person said, "Yes there are enough staff." A third person said, "There has never been enough staff. When you ring for assistance it takes a while for staff to come." Both relatives we spoke with felt there were enough staff to look after people.

The provider showed us the tool they used to calculate the staffing levels according to people's dependencies. The provider told us they were currently overstaffed by 23 hours per day. We looked at the duty rotas for the three weeks leading up to the inspection. These showed generally throughout the day there were a minimum of three care staff on duty and often four. During the week, in addition to these staff, there was usually the manager, an administrator, a cleaner, a cook and laundry person rostered to work part or all of the day. However, the rotas showed the laundry person had been absent for the last three weeks and was on holiday when we carried out the inspection. At the times we inspected there were four care staff, the administrator, the cook, the cleaner, the manager and the provider on duty. There were also up to six external consultants present who were supporting the provider. We observed staff were present in communal areas and responded to people's needs. However, the rotas showed, at weekends, although the care staffing levels remained the same there was no cook or laundry person working on either day and no cleaner on Sunday. This meant the care staff had to carry out these additional duties as well as provide care and support to people.

At our last two inspections we raised concerns about the staffing levels at night and our concerns remained as these had not changed. There were two care staff on duty from 10pm until 8am to meet the needs of people accommodated in rooms on three separate floors. Staff told us four people required two staff to assist them. Due to the limited space in some bedrooms a mini hoist was used at night which meant staff had to transfer the hoist between floors. In addition staff told us one person had a sensor mat in place as they walked around at night if they were not really tired. This placed people at risk of harm as when both staff were attending to a person there were no staff available to respond to other people's needs. Staff told us they were also allocated cleaning tasks to do at night which included cleaning the floors, furniture, walls and ceilings in communal areas and major appliances in the kitchen. Staff told us if they were working on the top floor of the home they could hear when a call bell was activated but could not determine the location as there was no call bell panel on the top floor. They said they had to go down to the middle floor to find out where assistance was needed. This was a continued breach of Regulation 18 of the Health and

Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found risks to people were not always well managed. For example, one person's care records showed they were at high risk of falls and required the support of one staff during the waking day. This was confirmed by the manager. We saw accident reports for this person which showed they had had six unwitnessed falls since May 2017. One of these accident reports showed another person living in the home alerted staff that the person was on the floor. On two other occasions in August and September 2017 the accident reports showed staff were busy attending to other people when the person fell. We saw another accident report in September 2017 which showed an unwitnessed fall for a different person. This showed staff had found the person on the floor as the person had been trying to assist another person into a chair.

Records we reviewed identified specific risks relating to a safeguarding incident involving two people in the home. The records detailed actions to be taken to mitigate those risks. We saw these were not actioned which meant people remained at risk.

Similarly we had concerns about how some environmental risks were managed. We asked to see the Personal Emergency Evacuation plans (PEEP) for people living in the home. A PEEP is intended to show the level of each person's ability to understand and respond to any evacuation of the building. The provider told us these were being updated on the computer and later in the day they brought us printed copies together with the PEEPs which had been in place previously. We found the updated PEEPs did not always provided sufficient detail about the assistance people required. For example, one person's PEEP stated the method of evacuation was 'Physically assisted with the aid from staff from bed/chair into wheelchair'. There was no information to show the person used a hoist or had behaviours that challenged, both of which had been detailed in the previous PEEP. We saw emergency fire sledges were positioned on the stairs, yet when we asked one staff member if they had been shown how to use this equipment they said no.

On the first day of the inspection we saw the car park was blocked with cars. We heard the ambulance crew report their concerns about this to a staff member when they brought a person back from hospital. We asked the provider on the second day if the concerns had been reported to them and they said no. We highlighted the car park was again blocked with cars which remained the same when we left the home. This meant emergency vehicles would not have been able to access the car park and potentially hampered any evacuation of the home.

We saw a risk assessment for the staircase dated 11 April 2017 which stated warning signs should be put on doors and yellow strips put on the stairs to highlight the first step on the first and second floor. We checked if these were in place and found signs on the doors opening onto the staircase which warned people to mind their step, but did not identify the hazard. There were no yellow strips in place on the stairs.

We found hot water temperatures at the wash hand basins in two toilets were above 44°C. The Health and Safety Executive recommend water temperatures should not exceed 44°C as this puts vulnerable people at risk of scalding. The manager told us water temperature checks were carried out by the night staff who checked three hot water outlets each night. We saw records for September 2017 showed 11 occasions when the hot water temperature in seven different bedrooms was between 45°C and 50°C. We saw the monthly health and safety audit for September 2017 had a section for checking water temperatures but this had not been completed. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the home was clean and smelt fresh. Maintenance and servicing certificates we checked for the premises and equipment were up to date and compliant.

We saw some safeguarding incidents had been referred to the local authority safeguarding team and notified to the CQC. However, we found three incident reports which showed people had sustained unexplained bruising and safeguarding procedures had not been followed. This was a breach of the Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe recruitment procedures were in place to ensure only staff suitable to work in the caring profession were employed. This included requesting a criminal record check with the Disclosure and Barring Service (DBS) and two written references.

Inadequate

Is the service effective?

Our findings

At our last inspection we identified concerns relating to the training and support staff received. We found similar concerns at this inspection.

We looked at the induction and training records for two recently recruited staff. We saw both had completed an induction orientation. We spoke with one of these staff who told us this comprised of a week shadowing the manager and senior care staff and included a medicines observation. They said they had also completed training in dementia care, continence care and the electronic care system and had been shown the fire procedures. We saw neither of the staff had received training in moving and handling or safeguarding; this was training which the provider identified as mandatory.

The training matrix given to us by the provider showed gaps where there were no dates to show staff had received training. Other entries demonstrated training was not up to date. For example, 13 out of 22 staff listed had no dates for safeguarding training, eight other staff had not received any updates in the last two years, two of these staff had last received training in 2010. Nine of the 22 staff had no dates for fire safety training. Thirteen had no dates for health and safety training. Some training updates had been booked for the near future in areas such as first aid, health and safety and safeguarding. The manager told us two recent training sessions had been held on dementia care. On the first day of our inspection there was a dementia care training session and also medicines training.

The manager told us supervision records were kept in the staff files. The annual supervision planner showed staff had received regular supervisions, however when we checked staff files we found this was not accurate. For example, the planner showed one staff member had received three supervisions this year and another staff member had had five supervisions. However, when we checked the staff files the most recent supervision records were dated June 2016. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). 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 manager and staff knew which people had DoLS authorisations in place and a list was displayed in the office which showed the expiry dates and identified if there were any conditions. One person had a condition attached to their DoLS which we found was not being met. The condition stated a MCA assessment and best interest decision should be recorded for the use of bed rails. Although there were MCA

assessment and best interest forms in the person's care file these had not been completed. On the second day the manager provided us with a copy of these documents, however these were not dated or fully completed and there was no evidence to show who was involved in the decision making.

Staff told us and we saw three people had sensor mats in their bedrooms which were connected to the call bell system and alerted staff when these people got out of bed. There were no MCA assessments or best interest decisions recorded for the use of this equipment. This was a breach of the Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people we spoke with said the food was good. Two people told us the quality of the food could be better. Comments included; "The meals are all right"; "The food is all right. You get a choice"; "The food is fine. There are always choices. They [staff] ask you what you would like the day before" and "The meals are good here."

The chef told us menus followed a two weekly rota which ran for six months then changed in the summer and winter. They advised a choice was offered at each meal and they had recently introduced a cooked breakfast which was available one day a week. The cook confirmed the care staff did the breakfast, evening and weekend meals, although they said they did as much preparation as they could to help. The chef said they fortified the meals for everyone using full fat milk and cream. A list of people's dietary needs was displayed in the kitchen.

We observed lunch time in the dining room and found it was a relaxed and sociable occasion. Staff chatted to people and we saw people responding and laughing. We saw tables were set with cloths, mats and condiments. Staff brought people their meals and provided support by sitting with those who need encouragement and assistance to eat. We saw people were asked if they wanted second helpings. The food looked tasty and when we asked one person what they thought of the meal they replied, "It's lovely. I'm enjoying it." People were offered a choice of hot and cold drinks

We did not see any specialist equipment such as adapted cutlery or plate guards offered or provided to people. We observed one person who would have benefited from a plate guard as they pushed their food around their plate and onto the table mat and table cloth.

We saw food and fluid charts were in place for people who were low weight or identified as nutritionally at risk. We saw people's daily fluid intake was monitored and recorded. However, there was no evidence to show the same monitoring was taking place to ensure people were receiving sufficient to eat. We also found inconsistencies in the recording. For example, on the first day of our inspection we saw one person refused lunch and only ate dessert and this was recorded in their daily records. However, their food and fluid chart recorded they had eaten a full meal and dessert. We had identified similar concerns at our previous inspection. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One relative confirmed that health care professionals were called when needed and hospital appointments were maintained. They said, "Staff keep me up to date about how my (relative) is. A while ago (my relative) had pressure sores and the district nurse advised staff to lay (relative) on the bed after lunch each day, which they did. (Relative) is now better." The care records showed people had input from different healthcare professionals such as GPs, district nurses, the community mental health team, chiropodists and opticians. However, we also found specialist support was not always sought in a timely way. For example, care records identified in August 2017 that one person required a dentist and needed to register with one. We asked the manager if this person had been seen by the dentist and they advised the person was still waiting as they

had only submitted the registration form the week before our inspection.

Requires Improvement

Is the service caring?

Our findings

At our previous inspections we found people's privacy and dignity was not always respected.

Most people we spoke with told us they thought that the staff were kind and caring. Comments included; "Some of them (staff) are kind and caring but some can be abrupt. They are mostly all right. One or two of them I don't like and probably they don't like me"; "They are lovely charming girls. There are quite a few new ones. Overall, yes the staff are caring"; "The staff on the whole are okay. The seniors are good. The older ones are the best. The younger ones are just in it for the money" and "The staff are all right."

Relatives also praised the staff and made the following comments; "The staff are very conscientious. They are good and they look after (relative) very well. There are new staff – they seem to be quite a young bunch" and "I do think my (relative) is well looked after. Staff are very caring. They love him."

We observed staff were caring, patient and kind in their interactions with people. We saw when staff came into the communal areas they spoke with people, listened to what people had to say and gave them time to respond to any questions. For example, we saw staff tried to persuade one person to have some lunch which they refused. They were gentle with the person and although they could not persuade them to have their main meal they brought some dessert for the person who ate it with relish. We saw staff asking one person about their visit to the hairdresser, asking other people about things they wanted to see on the menu in future and activities they wanted to be supported with that morning. There were also friendly and person-focused conversations relating to offering drinks and biscuits. Staff we spoke with knew people well. We saw people were relaxed in the company of staff and laughed or smiled when chatting with them. Where people did not respond we saw staff remained animated and encouraging when talking to them.

Overall we observed staff treated people with respect and ensured their privacy and dignity was maintained. For example, we saw staff were calm and considerate when assisting people with the hoist. We saw they explained what they were doing and reassured the person throughout the procedure. We saw staff ensured people's modesty was maintained by checking their clothing was not displaced. People looked well-groomed and were comfortably dressed. We observed staff knocked on people's doors before they entered. One person told us, "The staff always knock on my door."

However, there were isolated instances where people's privacy and dignity were not respected. For example, we saw one person sat in the communal area with their trousers unfastened and open. We asked a staff member about this and they said there was nothing they could do as the person kept undoing them and this happened all the time. There was no information about this in the person's care file and no evidence to show any action had been taken to try to explore the reasons why this kept happening or address this matter. This compromised the person's dignity and also showed a lack of respect for other people sat in the communal area. Another person had told us at our previous inspection that they did not always feel safe because their bedroom was used as a thoroughfare. At this inspection they told us nothing had changed. There were three doors in their bedroom. One led to the ensuite toilet and the other two doors led out onto separate corridors. The person told us, "The staff still use my room as a thoroughfare. They come and go as

they please. I felt safer in my previous little bedroom than I do in this larger room as I could lock my door."

We saw personalised information in people's care plans which showed individual preferences such as times they liked to get up, food likes and dislikes, interests and hobbies. Some people also had detailed life histories which painted a picture of the person including important relationships, working history and lifestyle.

People told us their choices were respected by staff and their independence was promoted. One person said, "I get dressed by myself, but one of the carers helps me with a bath." Another person commented, "I can do as I please. I get myself dressed and I get up go to bed as I want."
A third person said, "I can get up and go to bed as I want and the staff help me with this."

Requires Improvement

Is the service responsive?

Our findings

At our previous inspections we found people's care plans were not person centred, up to date or accurate. At this inspection, we found similar concerns. Although there was some personalised information, care plans were not always accurate, up to date or reflected people's current needs.

The manager told us they were in the process of transferring all the care documentation onto an electronic care system. They told us they had reviewed, updated and inputted 13 people's records onto the system. They said new staff had received training in how to use the electronic system but this was not yet up and running and staff continued to work from the paper care records. They also told us 'grab sheets' had recently been introduced for each person which provided an up to date summary of their care needs.

We found care records we reviewed were not always accurate, up to date or reflected people's current needs. For example, one person's care plan, although very detailed, had not been updated since August 2017 and the grab sheet did not fully reflect the person's care needs. The care records showed the person had bed rails, required their bed to be at the lowest level, required a pressure relieving cushion and mattress and had their medicines crushed. None of this information was on the grab sheet which was undated and unsigned. The grab sheet asked if the person had any known behaviours that challenged which had been answered no, yet the person had a behaviour chart in place. Daily records showed this person had sustained a skin tear following a fall in September 2017 yet there was nothing about this in the person's care plan. Another person's care plans had not been reviewed or updated since July 2017. We saw this person had a large bruise which staff told us was being treated by the district nurses, yet there was no reference to this in the person's care plan or on their grab sheet. A further person's care plans were dated February 2017 and had last been reviewed in August 2017. Staff told us this person had a sensor mat in place at night and we saw this in their bedroom, yet this was not reflected in the person's care plans or grab sheet.

We found one person, who the manager told us required a hoist for all transfers, was accommodated in a bedroom where space was severely restricted. We asked the manager to bring the hoist to the bedroom as we were concerned there was not enough space to hoist the person safely. We saw the space between the bed and furniture was only marginally larger than the width of the hoist and the furniture had deep gouges from where the hoist had made contact. The manager told us a reviewing officer had visited in August 2017 and recommended a re-assessment of this person's moving and handling procedures. The manager said they were looking at offering the person a larger room. However, we were concerned no action had been taken to address this matter. We looked at this person's care plans which were dated February 2017 and had last been reviewed in August 2017 and this was not reflected in the care plans or grab sheet. Following the inspection we referred our concerns about this person to the local authority safeguarding team. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people about activities in the home and they made the following comments; "I go downstairs most days but I am having an off day today so I am staying in my room. There are activities sometimes like skittles but not always"; "Yes they do have activities here" and "the activities vary. There is always something

going on."

The manager told us one of the care staff was allocated to provide activities each day and we saw this was reflected on the duty rota. We saw a list of daily activities was displayed in the entrance hall. In the morning a staff member spent time with people asking them what activities they thought they may enjoy. A quiz took place in the lounge in the morning. Most questions were answered by the same person and the activity did not gain much engagement from other people. The staff member was animated during the activity, but did not try to engage everyone in the room. When the quiz ended there was a game of floor skittles which we saw people engaged with and clearly enjoyed. Another quiz took place in the afternoon which people enjoyed as there was much laughter.

Activity records showed what people had participated in, how their engagement had been agreed, whether people had enjoyed the activity and an observation of their mood. They were brief and showed a repetitive programme of activity.

People and relatives we spoke with knew who to speak to if they had a complaint or any concerns. One person said, "I would speak to the manager or owner if I had a complaint. If there is something to complain about it is waiting to have to go for a pee." Another person said, "I would speak to one of the carers or the manager if I had any concerns."

A complaints procedure was displayed in the home. The provider told us no complaints had been received since the last inspection in April 2017 and this was confirmed in the complaints file we reviewed.

Inadequate

Is the service well-led?

Our findings

At our last two inspections we identified shortfalls in the leadership, management and governance of the service. Following the inspection in April 2017 the provider sent us an action plan showing the action they were taking to address these issues and improve the quality of the service. This showed all but three of the actions would be completed by 4 October 2017. However, at this inspection we found continued regulatory breaches. We concluded the service was not well-led.

The provider told us the external consultant they had engaged following the inspection in April 2017 had left and a new team of consultants had begun working with the provider five days before our inspection. The provider gave us a new action plan which had been developed by these consultants.

We saw audits were in place for areas such as infection control, health and safety, medication and the environment. However, we found the provider's governance systems were not effective in identifying or resolving issues and ensuring improvements were sustained. For example, we saw a medicine audit in May 2017 had identified PRN protocols and staff medicine observations were needed; both had been ticked as done yet we found these were not in place. Further medicine audits had been carried out in June, July and August 2017 which stated no issues had been identified. We saw an infection control audit dated 28 August 2017 which included a mattress audit. This audit concluded there were no issues with mattresses, although a handwritten note stated 'see mattress sheet'. When we asked the provider for this supporting documentation they said there was none. This meant we could not establish what checks had been carried out and whether this was a sample of mattresses or every mattress. We saw an environmental audit dated 2 October 2017 which identified a number of actions, but there were no dates by which they were to be completed. For example, we found the audit identified a slope outside one person's bedroom which was not clearly defined and the action was to place a sign near the slope. We checked and this was not in place. This trip hazard not been identified in the environmental audits completed by the provider.

We saw audits completed in August and September 2017 for care plans, nutrition and safeguarding. However, these contained very little information and it was not clear what checks had been carried out, who had completed them or when.

Care records we reviewed showed the provider was not maintaining accurate, clear and contemporaneous records for people who used the service.

We asked the provider for any reports they had completed since the last inspection as part of their quality monitoring of the service provision. The provider told us as they had been in the home every day they had not completed any and asked if they needed to do this.

We saw falls, accidents and incidents were audited monthly. However, we found the analysis was limited. For example, it was not clear who had completed the audits in May, June and July 2017. Although some actions were listed to lower the risk to individuals there was no overall consideration of themes or trends. The audit for September 2017 listed only three accidents yet we found eight accident reports for September

2017.

The provider told us surveys had been sent out to relatives in July and August 2017. Four had been received back. We saw three of the surveys showed relatives were satisfied with all aspects of the service. The other survey raised some issues however it was not clear what action had been taken in response. The provider told us the surveys had not been reviewed or analysed yet.

We saw staff surveys had been sent out in July 2017 and eight had been received back. We saw issues had been raised about staff not having enough time to work on or update care plans and not enough staff. The provider told us the results had not been analysed.This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the provider had not submitted all required notifications to the Commission. We saw an accident report which showed a person had been taken to hospital following a fall as a serious injury was suspected. We saw reports of three incidents which had been referred to the local authority safeguarding team. 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. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager left the service in February 2017. One of the senior care staff had taken on the manager's role and had been in post for one month when we carried out this inspection. Staff spoke positively about the manager and the changes they had made since starting in post. One staff member said, "There have been changes. There is more structure. Some staff attitudes have improved. (The manager) is brilliant. She makes decisions, she won't let staff take liberties. She is 100% for the residents." Another staff member said, "(The manager) is very good. She promotes a personal approach, makes sure the residents have choice and are treated with respect. There's been staff changes, it's better now as before some staff didn't care." A third staff member said, "There's been lots of improvements, training is more regular and (the manager) and (provider) are trying really hard and are more approachable."

Overall, people living at the home told us they thought the home was well run. All those we spoke with apart from one said they would recommend the home to others. Comments included; "Overall, it is ok. I don't know if I would/would not recommend the home"; "Yes, I would recommend the home to people" and "When I first came here it was well run and then it declined. I think things are improving and getting better. I would recommend the home to people. I think it is one of the best ones in Halifax. Overall, I am quite satisfied with the care and everything" and "I am all right here. Overall, I am quite happy with everything. There is no trouble here."

We asked people we spoke with if they felt involved with the running of the home and how this was facilitated. People told us there were regular residents/relatives meetings held at the home. Comments included; "Yes they do have residents meetings my family comes to them" and "Yes I think they take place once a month. We are also fed back what action the home has taken." We saw minutes from meetings held in June and August 2017.

A relative told us, "Yes there are residents meetings. There is one tomorrow night at 6:30pm. Overall, I would definitely recommend the home. Things have improved. Activities have increased. Communication – staff keep us informed more through the resident meetings."

We saw staff meetings had been held in August and September 2017. We saw the rating from the inspection

in April 2017 was displayed in the home as required.