Roche Healthcare Limited

Hartshead Manor

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected Hartshead Manor on 17 and 25 July and 2 August 2018. This inspection was unannounced.

Hartshead Manor is a care home for up to 55 people. At the time of this inspection there were 49 people living at the home (47 on second and third days). People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Hartshead Manor consists of one building with two floors and had one unit specialised in providing care to people living with dementia.

Hartshead Manor was last inspected on the 4 and 6 April 2017. At that time it was rated requires improvement overall and was in breach of regulations in relation to good governance because of lack of records of people's food and fluid intake, inconsistent administration of prescribed drinks and poor auditing of water temperatures, care plans and medications. This was the third time this service was rated required improvement. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve their well led domain to at least good. At this inspection we found not enough improvements had been made in the areas identified, the provider was in continuous breach and we found further concerns in relation to safeguarding, safe care and treatment, meeting nutritional and hydration needs and consent.

At the time of this inspection the service had a home manager who had not registered to manage the service. It is a legal requirement that the home has a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

We found systematic and widespread failings in the oversight, monitoring and management of the service, which meant people did not always receive safe care.

We found concerns about how people's nutritional and hydration needs were being met and the registered provider was not managing people's weight loss safely. During this inspection we raised safeguarding concerns in relation to people losing weight.

The management of risks was not always consistent. We found people using specialist pressure relief chairs had not been assessed to use this equipment. We found manual handling risk assessments were not always person centred and lacked detail about how people should be moved.

Medicines were administered in a caring way however we could not be certain these were always administered as prescribed or stored safely.

Mental Capacity Act 2005 assessments and best interest decisions for some people living with dementia were in place however the relevant people had not always been involved. We saw relatives giving consent for decisions without having lasting power of attorney. There was no evidence people were being restricted or receiving care that was not in their best interests.

Staffing levels were not always sufficient to ensure people received the care they needed in a timely way, in particular during meal times.

There was a regular and varied programme of activities at the home and people spoke positively about the activities coordinator however we found people were not offered enough social stimulation throughout the day and spend long periods of time sitting in the lounges.

Staff told us they received training and supervision they needed to provide people with effective care and support however we found some staff had not had their competencies recently assessed and their supervisions were overdue.

The registered provider was in the process of implementing a new electronic system to manage people's records of care. At this inspection we found notes related to people's daily care and food and fluid were not always accurate of the care delivered.

People's needs in relation to the protected characteristics under the Equalities Act 2010, were taken into account in the planning of their care. People's communication needs were assessed.

There were safe recruitment policies and procedures in place.

People and their relatives told us staff were kind and caring.

The registered provider kept links with the community and worked in partnership with local organisations.

Staff told us they felt supported by the management team and people spoke positively about staff. Our findings at this inspection indicate management's oversight was not robust.

There were several systems in place to monitor the quality of care however these were not effective in identifying the issues found at this inspection.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Where regulations have been breached information regarding these breaches is at the back of this report. Where we have identified a breach of regulation which is more serious we will make sure action is taken. We will report on this when it is complete. Where providers are not meeting the fundamental standards we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service.

When we propose to take enforcement action our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures. This is the first time the service has been 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.

We identified safeguarding concerns during this inspection.

Medication was administered kindly but we could not be certain it was always administered as prescribed.

The provider's approach to risk management was inconsistent. Some risk assessments were detailed, others were not.

Records were not always accurate or up to date.

There were safe recruitment policies and procedures in place.

Is the service effective?

Requires Improvement

The service was not always effective.

The home was not fully compliant with the Mental Capacity Act 2005.

People's nutritional and hydration needs were not always managed safely.

Staff had received some training, supervision and appraisals to support them in their role but this was not always up to date and in line with the registered provider's policies.

Is the service caring?

Good

The service was caring.

People and their relatives described staff as kind and caring. Our observations throughout the inspection supported this.

Care staff promoted people's dignity and respected their privacy.

We observed people and care staff laughing together.

People's end of life wishes were assessed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans were regularly reviewed however the information was not always updated to reflect people's current needs.

There was an activities programme in place but we saw people spending long periods of time without social stimulation.

Is the service well-led?

Inadequate

The service was not well led.

Staff told us they felt supported by the management team however we found management's oversight was not robust.

The systems for monitoring and checking the quality of care provided were not effective.

The registered provider had not taken appropriate action to ensure the service was compliant with the regulations.

Hartshead Manor

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.

The inspection was prompted in part by CQC's ongoing monitoring of the level of risk at Hartshead Manor followed by notification of an incident which had resulted in the unexpected death of a person living at the home. This incident is being reviewed by CQC in line with our specific incidents policy. Therefore, this inspection did not examine the circumstances of the specific incident.

This inspection took place on 17 and 25 July and 2 August 2018 and it was unannounced.

The inspection was completed by one inspector and an Expert by Experience on the first day and two inspectors on the second and third days. 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 Expert by Experience had experience as a family carer of a person living with dementia who used domiciliary care services.

Before the inspection, we reviewed all the information we had about the service including previous inspection reports and notifications received by CQC. A notification is information about important events which the service is required to tell us about by law. We used this information to help us decide what areas to focus on during our inspection. The provider sent us a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We discussed this information during the inspection. We requested and received feedback on the service from the local safeguarding teams and commissioners.

We spoke with seven people using the service and five relatives. We spent time observing care in the communal lounges and dining rooms and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us.

We also spoke with eleven staff; this included the nominated individual, home manager, nurses, senior team leaders, catering staff, activities coordinator and care workers. We looked at support records for four people using the service including support plans and risk assessments. We also looked at specific parts for care plans for four people. We looked at four medicine administration records. We reviewed the home's training matrix, looked at training, recruitment, supervision records and medication competencies for three staff. We looked at minutes of team meetings, staff and relative surveys, various policies and procedures and reviewed the quality assurance and monitoring systems of the service.

Inadequate

Is the service safe?

Our findings

People told us they felt safe using the service but relatives shared concerns about people's safety. People's comments included, "Very safe," I feel settled here would not like to move," "I get on with everybody, If I don't like anything I tell them." Relatives told us, "It's not fully safe as [relative] gets up to help beyond [relative's] capabilities, there should be staff around to help [relative]."

People were not always protected from abuse and neglect. We found one person had lost 14.8kgs between 18 April and 21 July 2018. When we asked staff for evidence of referrals made to relevant healthcare professionals we saw staff had made contacts but did not actively followed up their referrals; it was not clear whose healthcare professionals had visited. At our last inspection day we were informed this person had been taken to hospital. We discussed this concern with the home manager and nominated individual who said they would investigate it and we reported it to the local safeguarding team.

During this inspection, we found another person had lost 9.4kgs between 23 Dec 2017 and 20 April 2018. This person had been seen by healthcare professionals during this period but the reasons were not related with managing weight loss. We shared our concerns with the home manager and they told us this person was overweight and their current weight would not have triggered a referral to the GP. However we shared our concerns about this person losing weight without a healthy diet plan in place and the impact on their medical conditions. We reported this concern to the local safeguarding team. We reported a third safeguarding concern in relation to one person not being repositioned or supported with their personal care needs for up to five hours.

The home had a safeguarding policy and procedures in place, staff had been trained in these and were able to tell us the signs of abuse that they would look out for and what steps to take if they had concerns. One staff member told us, "I would inform my team leader, nurse or manager." Records at the home showed concerns about people had been raised with the local authority safeguarding team and some, but not all, had been reported to CQC. We shared our concerns with the nominated individual and they told us they would investigate it.

These findings constitute a breach of Regulation 13 (2) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 and Regulation 18 of The Care Quality Commission Registration) Regulations 2009.

Risks to people's care were not always managed in a consistent way. We saw care records included risk assessments in relation to people falling, using bed rails, developing pressure sores and swallowing difficulties. However, we found two people were using specialist pressure relief chairs but had not been assessed to use this equipment. These people had pressure ulcer prevention care plans that indicated they needed to be repositioned every four hours but did not explain the method staff should use when repositioning on the chair. When we spoke with staff they told us they would reposition these people every two hours. However daily records did not show this was happening. We could not be certain people were receiving care that had been assessed to their needs. We shared our concerns with the nominated

individual, requested information on three occasions but the information provided continued to lack detail and was not person centred.

People could not be reassured staff would always administer medication as prescribed. One person who had been prescribed with an 'as and when required' medication to manage their agitation did not have a medication care plan in place or a PRN protocol to guide staff. We asked staff when they would administer this medication; one said "[Person] would say", other said "When staff identify [person] is agitated. Staff would just know." Another person had been prescribed with medication "to be taken once daily 30 minutes before food" and their medication record indicated this should be given during the morning. During our inspection this person had their breakfast at 8:40 am, medication was given at 9:40am and they were offered a snack at 11:35am. Another person had been prescribed medication to be taken "30 minutes before breakfast and at least two hours apart from calcium tablets" but during one of our inspection visits we observed this person had not had their medication administered by 1.10 pm. We spoke with the home manager and nominated individual about these concerns; they did not agree with our findings and stated it was a recording issue.

The service had a medicines policy and procedure in place. Medicines were stored in people's bedrooms to promote independence and person-centred care. Medicine records for each person contained personal information, the type, quantity and time the medicine should be administered. Records showed staff who administered medicines had the appropriate training however some had not had their medication competencies checked regularly. National guidance issued by the National Institute for Health and Care Excellence (NICE) recommends staff should have their medication competency assessed every year. People's medication file had an area for staff to record the room temperature but we found several gaps in recording. It is important that medicines are stored within a temperature range to make sure they do not change their composition or lose their efficacy. We shared our concerns with the home manager and nominated individual.

These findings constitute a breach of Regulation 12 (2) (a) (c) (e) (g) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

We received mixed views about staffing levels at the home. People told us, "They come quickly if I ring my buzzer" and "don't have to wait long". Relatives told us, "Not enough staff cover in the lounge, occasionally had to look for staff", "Mostly enough staff but have had to find staff when in the lounge to take [relative] to toilet" and "A while ago when visiting, a [person] in a wheelchair was left at the dining table so long [person] was sick, no staff around so I called for help." One visiting professional told us, "they seem a little under staffed, no staff in the lounge area and these residents should have 24 hour supervision and not be left un-supervised." One member of the inspection team also had to call staff as one person was asking for help and not being attended to. One staff member said, "nursing staff needed to be increased as they are stretched to meet the needs of people." On our second inspection day there were five carers, one nurse and one senior team leader working on the floor at 9.15am; the second senior team leader had left the building to attend a meeting and returned at 12:30 pm. These were not the staffing levels we were told by the home manager that should be in place. The home used a tool to determine staffing levels according with people's dependency levels and the home manager and nominated individual told us they felt the staffing levels were appropriate. We asked them to review this, in light of our findings and observations.

Our observations of the meal time experience in the dementia unit showed there was not enough staff to provide people with the supervision, encouragement and assistance they required in a timely way. When we looked at accidents and incidents reports for the last 3 months we saw the home was having on average 10 falls a month, these were mostly unobserved and happened during the morning period. We asked the home

manager and nominated individual what actions had been taken to address this, they told us they had made changes to people's individual care as a result of their falls. We asked if the provider was analysing the information about people's falls for any trends or patterns; no evidence was provided of this. However the provider also told us they had identified in May 2018 an issue with recurrent falls and they were planning to develop safety huddles in partnership with the local university in September 2018. Due to the potential impact that a fall can have on a person's health, we shared our concerns about the 3 month gap between identifying the issue and making the organisational changes to address it.

Records were not always accurate or up to date. The registered provider was in the process of implementing a new electronic system to manage people's records of care. At this inspection we found notes related to people's daily care and food and fluid were not always accurate of the care delivered. For example, one person's daily records indicated they had been hoisted and their wheelchair checked but this person was independently mobile. Another person's daily records did not indicate what time they had been supported with their meals and medication and their need to take their medication 30 minutes before food. We discussed our concerns about inaccurate record keeping with the home manager and nominated individual.

The service followed safe recruitment practices. The provider had a staff recruitment procedure in place. The process assured the provider employees were of good character and have the qualifications, skills and experience to support people using the service.

The environment was safe for people. We saw safety checks had been completed on time, there were no obvious trip hazards and communal areas were clean. We saw staff followed good hand hygiene procedures and protective equipment such as aprons and gloves were available throughout the building. We observed housekeeping staff cleaning people's rooms and good practice was followed in separating soiled linen and clothing and keeping cleaning materials locked away when not in use. Subsequent to the inspection we were provided with information that confirmed the registered provider had been awarded with a certificate of recognition by the local for achieving 93% in their annual infection prevention and control audit for the current year.

Requires Improvement

Is the service effective?

Our findings

During the inspection we gathered mixed information about the quality of people's meal experience. People's comments included, "Food adequate", "Very good food" and "Marvellous how they do the food; every meal they make is lovely." However, we also gathered information of concern about the way the home was managing some people's nutritional and hydration needs.

People in the dementia unit did not always have a good meal experience and their nutritional needs were not always met. Some people were served their meal but did not attempt to eat it by themselves. We asked staff if these people needed assistance and they told us that because so many people needed assistance they could not assist everyone at the same time. We observed one person taking food from another person's plate. We observed one person struggling to eat for three minutes due to their poor coordination, staff then came to support this person with main meal and when they finished staff left the dessert on their table but did not assist them straightaway. Another person was given their meal in their bedroom; at 12.55pm they were given desert, at 1.20pm we saw this person had not eaten and was mixing the food with their hands. We checked these people's records and both had been losing considerable amounts of weight in the last six months but their care plans had not been updated or contacts made to professionals in relation to weight loss. We discussed our concerns with the home manager and nominated individual and asked them to review the weights of every person living at Hartshead Manor. Their investigation showed five people had lost more than 3 kgs since the last time they had been weighted and four of them had not been referred to the GP or dietician due to concerns with weight loss prior to our enquiries. The home manager and nominated individual told us these people were going to be referred to GP, staff were starting a new food and fluid training plan in the next weeks and they were going to introduce a weights file and use the new digital system to regularly monitor and act on people's weight loss.

People's food records did not always evidence how much had been offered and how much people had eaten therefore the registered provider could not be certain of how much food people were having. We shared our concerns with the home manager on our second visit and on our third visit we saw evidences that staff were starting to add more detail into people's food records but the practice was not consistent yet. When we looked at people's hydration records, we saw some people were offered very low quantities of fluid throughout the day. One person's records showed that on three consecutive days they had been offered substantially less than the recommended quantities. The NHS recommends an adult should take about 6 to 8 glasses of fluid every day. We asked one senior staff member how much people should be offered during one day and they could not tell us. We informed them of the quantities recommended by the NHS.

These findings constitute a breach of Regulations 14 and 17 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Dining rooms were set nicely with cutlery and napkins. The menu had two choices of main meal at lunch and one at the evening meal with a choice of dessert. We observed staff offering people a choice of meal. We saw records of people's dietary needs in both care plans and the kitchen area and a kitchen staff member we spoke with was able to describe the different consistencies of food they had to prepare and how they

were updated about people's dietary requirements.

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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The service was not fully compliant with the MCA. Assessments and best interest decisions for some people living with dementia were in place however the relevant people had not always been involved. For example, the decision of "declining de insertion of a (specialist feeding tube) (due to) high risk of aspiration when eating and drinking" was considered for one person however no healthcare professionals were involved in making this decision. Two people were using specialist seating but the home had not followed the required process to make this decision. For example, one person's mental capacity assessment had only been completed by one staff member, there was no evidence of involvement from family or staff with specific seating/manual handling training. This person's best interest decision was not filled in. Another person had a mental capacity assessment and best interest decision that were not specific for the decision regarding seating equipment. Records showed relatives were asked by the home and were giving consent for decisions without having lasting power of attorney. There was no evidence people were being restricted or received care that was not in their best interests.

These findings constitute a breach of Regulation 11 (3) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

During our inspection we confirmed people had access to healthcare professionals but as evidenced above people's health care needs were not always managed in a way to ensure they received specialist support in a timely way from healthcare professionals. We spoke with one visiting healthcare professional who told us they had no concerns regarding people receiving healthcare assistance when needed.

We looked at the induction and training that staff received and we saw evidences of this being completed however not all staff's medication and manual handling competencies were up to date. Staff told us they had received training relevant to their work. We spoke with the home manager and nominated individual about some staff's training being overdue and they told us they were going to addressing this matter within the next six weeks.

Staff we spoke with told us they received regular supervisions as well as an annual appraisal. The home manager told us they aimed to complete supervision every three months. When we looked at the supervision matrix we saw this was not always happening and there were 5 staff in a total of 26 that had not had a supervision or appraisal for more than three months. Some of the staff members that had not had their supervision were in a position of seniority. We discussed this with the home manager during our second visit and they confirmed they were aware of this; on our third visit we asked for an update but the home manager explained they had not completed any outstanding supervision or appraisals yet.

Some people living at Hartshead Manor experienced at times behaviours that may challenge others as a result of their dementia diagnosis and we saw examples of good practice. One person had a detailed and person-centred care plan that incorporated information from the person's personal history. For example, it suggested conversation topics for distraction when they became upset. We spoke with staff they were able

to describe this to us. Another person was known to become unsettled when there were being moved with a hoist and staff told us what they would do to reassure this person.

Good

Is the service caring?

Our findings

All people and relatives we spoke with told us staff were caring and kind. People's comments included, "Oh yes they listen to me and treat me with dignity", "They are kind." Relatives told us "The staff are excellent and treat [relative] with respect" and "They are really kind, nothing is too much trouble."

Some people and relatives told us they had been involved in planning and reviewing their care but when we checked the records these were brief and did not show how people had been involved. One person told us, "I saw my care plan some time ago" and one relative said, "[Relative] has not got a care plan yet as temporary (placement) but is going to be permanent." The home manager showed us letters she had sent to relatives to ask them how often they would like to participate in the review of their relative's care plans.

We observed positive and relaxed interactions between staff and people. We observed one staff member initiating an interaction with a person while walking through the lounge, "You have the best seat in the house" they said, to which the person replied, "Why don't you join us?" and staff replied, "I wish I could but I am not finished yet." Staff acted quickly when two people who used the service had an altercation over a handbag. The staff member calmly intervened and moved one person to another part of the lounge. Staff then returned to the other person and gave reassurance.

Staff took into account people's privacy and dignity. We saw staff knocking on a people's bedroom doors before entering. During our inspection, we saw people's files with confidential and sensitive information were stored securely.

People's needs in relation to the protected characteristics under the Equalities Act 2010, were taken into account in the planning of their care. For example, people's communication and specific health conditions were assessed. We looked at the care plan of one person living with dementia and saw they had hearing difficulties but family reported they never wanted to use hearing aids so staff were instructed to speak loudly and clearly. We observed one staff member speaking close to the ear of another person who also had hearing difficulties and the person indicated they were understanding.

We saw people's care plan had a section called "This is me" that detailed information about people's families, where they used to live and work. When we spoke with staff they were aware of this information and used it when necessary. For example, one person used to be an arts teacher and enjoyed colouring and we saw staff suggesting this activity.

We asked the home manager if people had used advocacy services, they told us they did not but the home manager explained they knew when to offer it to people and how to access this service.

Requires Improvement

Is the service responsive?

Our findings

People told us they felt supported by staff that knew them. They also felt able to feedback on the care they received if they had any concerns or complaints. One person said, "If I don't like anything I tell them". Other person commented, "I think they would act on things" Other people said they would prefer to speak with their family first if they had any concerns.

The home manager told us they assessed people prior to admission to the home. The pre- assessment included gathering information about people's needs and preferences. When we looked at people's care plans, we saw these were organised by sections which included information about people's medical conditions, personal care, mobility, communication, skin integrity, records of professional visits/referrals and end of life care.

The registered provider was assessing people's needs but we found the information in the care plan wasn't always consistent with the care people were receiving. We checked one person's care file and saw they had two medical condition's care plans but one was not fully completed and the other one was blank. Due to this person's health condition, their eating and drinking care plan indicated they needed to have their blood sugars checked weekly. We asked nursing staff if this was being done and they told us it was only done if person was symptomatic and not on a weekly basis as stated in the care plan. We checked two people's pressure ulcer prevention care plan and both indicated they required repositioning every four hours for pressure relief. When we spoke with staff they told us they would reposition these people every two hours. We found one person was being supported with their medication but did not have a medication care plan in place. We discussed this last concern with the home manager and nominated individual and asked for an update during and after the inspection but no evidence was provided that a care plan was put in place.

We saw people's care plans were regularly reviewed however changes in people's needs were not always prompting changes in people's care plans. One person's eating and drinking care plan had been regularly reviewed and staff had noted this person's weight fluctuated considerably in the last six months however no change was made to the care plan and referral to GP was only made in July 2018. Another person's eating and drinking care plan had been reviewed on 18 July 2018 and stated "Weight loss of 4kg since last review. Close observations at meal times required" but the review did not indicate what further action had taken place to address the person's weight loss and the care plan was not updated.

These findings constitute a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the systems in place were not effective in assessing, monitoring and improving the quality of care people were receiving.

There was an activities programme in place however we also observed people were not offered interaction for long periods of time. People spoke positively about the activities and activities coordinator. Comments included, "Activities [name of staff] comes to my room and plays dominoes with me and [staff] knows my favourite is quizzes so she brings a quiz book" and "They ask me to join in the activities, I have a bit of a laugh, they let me be in charge of the games." One relative said, "[Name of activities coordinator] puts one

hundred percent into everything, she goes above and beyond." The activities plan included boat trips, shopping trips, bingo, crafts, music quizzes, garden club. On one of our inspection visits children from a local nursery visited the home and sang for the residents.

Despite the activities being developed at the home, we observed that when the activities coordinator was going out with some people, the ones that remained at the home stayed in the lounge and no activities were offered. We looked at the activity records during June 2018 for two people in the dementia unit. The activities were varied and related to people's interests however these were not happening every day. For example, one person had been with the activities coordinator five times during that month. NICE guidance recommends that people living in care homes should be offered meaningful activities during their day to maintain and improve their mental health.

At the first inspection day the home was providing end of life care for three people. Staff told us they felt confident in providing end of life care and knew what actions to take if a person deteriorated. We saw people had been prescribed with anticipatory medication to manage pain symptoms. The home manager told us staff were trained in end of life care but when we looked at the training matrix and training records in staff's files file could not see evidence of this.

There was a complaints policy and procedures in place and people and their relatives told us they would feel confident to report any complaints or concerns. Most people we spoke with said that if they had complaints they would ask their families to support them dealing with them. One person said, "If I needed to complain I would talk to my nephew, he deals with everything" and another person said, "Would tell my daughter if I needed to complain." People also told us they were confident the management would act on their concerns; one person commented "I think they would act on things." Relatives' comments reflected those from people. One relative told us, "Recently had one complaint was dealt with immediately."

During our inspection we saw people were offered choice. We observed one person living with dementia had finished their main meal and start walking towards the balcony where food was held; one staff member followed this person, showed them desert and the person said, "This is what I want." We observed another staff asking a person if they wanted to do their nails, they said yes.

Inadequate

Is the service well-led?

Our findings

Since our inspection in April 2018, we found the service was in breach of regulations in relation to good governance because of lack of contemporaneous records of people's food and fluid intake, inconsistent administration of prescribed drinks and poor auditing of water temperatures, care plans and medications. At this inspection we found not enough improvements had been made in these areas, the service continued in breach and we found other areas of concern.

We asked people about the management of the home. Comments included, "Don't know who the manager is" and "The manager came to see me at dinner." Staff spoke positively about the management of the home. One said, "[Manager] is very approachable, I feel I could go to her or any other leader or the [name of the owner]." Other member of staff shared, "I am very satisfied, we had a few managers and it has been a bit disruptive because they try to implement changes; with (name of home manager) it is nice and stable." Despite these comments, at this inspection we found the service was not well-led.

The home had a manager who was in post since March 2018 but they had not registered to manage this service. It is a legal requirement of the home's registration that a registered manager in post. The home manager informed us they were managing this service on a part time basis because they were the registered manager of another home. They were planning to register at this location and told us they had discussed with the nominated individual the resources they required to be able to do so. We spoke with the nominated individual and they showed us they were actively and regularly involved with the management of the service.

We looked at action plans the management had put in place to address the areas of concern raised at last inspection and other areas they felt needed improving. During our inspection we saw some specific improvements had been made however these actions plans had not been effective in driving the overall improvements required in some areas. For example, these plans indicated that action was required and had been completed in relation to people nutritional and hydration needs, for example people at nutritional risk having food and fluid charts in place. However, at this inspection we found considerable concerns about the monitoring and recording of people's food intake and weight loss. The action plan indicated work was required in requesting evidence of power of attorney from relatives. During the inspection the home manager showed us letters sent to and received from relatives regarding this however people's care files still showed relatives giving consent for decisions they did not have the legal authorisation to make.

We found quality assurance systems were not effective in recognising or improving the issues found at this inspection. The service carried out various quality audits of records including audits of medication administration records, residents' files, infection control and equipment. We saw the service had developed corrective action plans in relation to medication. We saw the action plans in April and May 2018 identified issues with medication not being signed for in line with the service's medication policy; at this inspection we found this was still an issue. The action plan from April 2018 indicated medication counts were not correct; at this inspection we identified one person was missing two tablets. We saw evidence of audits being done to some resident's files by the home manager however these had not been effective in identifying some of

the areas that needed improvement such as risk assessments, care plans, reviews and consent.

During this inspection we found areas where the management's oversight and governance had not been robust. The home was implementing a new electronic system to manage people's records of care but the quality of the recording was not being monitored and we found records were not always accurate and relevant. Accidents and incident reports were being reviewed monthly and issues with recurrent falls had been identified in May 2018 but even though actions about specific people had been taken, the potential organisational changes action to address this concern was planned to start only in September 2018. During this inspection we found some staff had not had their competencies assessed to administer medication and perform manual handling manoeuvres. We also found some staff had their supervisions overdue.

During our inspection we found the registered provider had not always informed CQC of safeguarding incidents that had taken place and were being investigated by the local safeguarding team. This is important to ensure CQC can monitor the safety of the service people receive.

These findings constitute a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider used a survey and organised resident meetings to gain feedback from people. One person told us they had been invited and attended a residents meeting to voice their views about the home was run, they said, "I have been to a meeting; it was a good place where you could air your views."

Staff meetings were also regularly organised. We saw relevant discussions about the management of the home being held and when staff raised concerns, actions were agreed by the management to address these. For example, staff raised concerns about the quality of a specific training and the nominated individual showed what they had done to address these. We saw the owner had been involved in one of these recent meetings.

We saw the registered provider kept links and worked in partnership with the community. For instance, the home was developing safety huddles with the Improvement Academy at Bradford University to address the number of falls at the home.

Under the Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015, registered providers have a legal duty to display the ratings of CQC inspections prominently in both the office and on their websites. On our arrival at the home we saw the ratings from the last inspection were displayed.