Four Seasons 2000 Limited

Hemsworth Park

Inspection report

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Date of inspection visit:
23 May 2017
25 May 2017

Date of publication:
04 August 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Our inspection took place over two days, 23 and 25 May 2017. The first day of our inspection was unannounced, and we told the provider when we would be returning to conclude the inspection.

At our last inspection we identified five breaches of regulations. These related to dignity, safe care and treatment in relation to medicines management, nutrition and hydration, staffing levels and support and governance systems. At our recent inspection we found action had been taken to ensure improvements had been made in relation to medicines management and nutrition and hydration. The provider remained in breach of regulations relating to staff, dignity and governance. We also identified two further breaches of regulations relating to safe care and treatment and consent.

Hemsworth Park provides residential and nursing care for older adults, some of whom are living with dementia, and younger people with disabilities. It is arranged into four units, with communal living and dining facilities in each unit. There is a terraced outdoor area which some people could use. The home can accommodate a maximum of 93 people, and at the time of our inspection there were 82 people using the service.

There was not a registered manager in post when we inspected. 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. There was a manager in post who was still in their induction period. They were planning to register with the CQC.

People told us they felt safe living at Hemsworth Park, and we saw the provider ensured maintenance was attended to, including regular checks to fire, gas and electrical installations. Risks associated with people's care and support were not always well documented, and we saw some instances of poor risk management. We identified this as a breach of regulations relating to safe care and treatment.

Improvements in relation to the storage of medicines which we asked to be made had been actioned. We identified one medicines storage room and fridge had been regularly above the temperature recommended for the storage of medicines, and the provider took action on the day of our inspection to rectify this. Medicines administration was managed safely, with records kept fully up to date.

We saw recruitment was managed safely, with appropriate checks to ensure new staff were not barred from working with vulnerable people. However, we identified concerns with the numbers of staff on duty, and saw staff did not always get the support they needed to remain effective in their roles. These examples contributed to a repeated breach of regulations relating to staffing.

Staff had access to training which gave them the skills and experience needed to be effective in their roles, and people told us they had confidence in the staff's ability to care for them. The provider was undertaking

work to improve training, knowledge and environments relating to people living with dementia. Staff received an annual appraisal at which performance was discussed.

The provider was recognising when applications for Deprivation of Liberty Safeguards (DoLS) were needed, and we saw applications for renewals were being made in a timely way. People told us they felt able to make choices, and we found staff had received training which had given them an understanding of the requirements of the Mental Capacity Act 2005. However, we found consent documentation was not always completed appropriately, and concluded the provider was in breach of regulations relating to consent.

Feedback about meals served was generally positive from people who used the service, and less favourable from staff. We saw the provider had met with the catering supplier to discuss quality. We found the chef was knowledgeable about people's dietary needs, and some people who needed a specialised diet for health or cultural reasons told us they received this. People generally had good access to drinks when they needed them, which was an area we had told the provider to improve after our last inspection. On one unit we needed to ask staff to provide drinks for people who had been up for some time but had to wait for the breakfast service.

People were supported to access health professionals when they needed, although some referrals had not been followed up in a timely way. Records of visits were kept in people's care plans, and visiting health professionals gave good feedback about their experience with the service.

At our last inspection we saw one person who did not speak English did not receive adequate support, and asked the provider to take action. At this inspection we found there were two people who did not speak English, and little improvement had been made to ensure their care and support were effective and caring. We concluded the provider remained in breach of regulations relating to dignity.

People told us they had good relationships with staff who protected their privacy and dignity. We observed pleasant and patient interactions throughout out inspection. Staff had a good knowledge about the people they supported.

There was no one receiving end of life care at the time of our inspection, however we saw a lack of records relating to people's wishes in their care plans.

We saw care plans were reviewed regularly and staff told us they received updates when people's care and support needs changed. We found changes were not always immediately obvious in care plans, however.

People gave generally positive feedback about activities in the home, however staff told us more could be done in this area. Although there was information about people's interests and hobbies in some care plans, we did not see this followed up to ensure people were supported to maintain these interests.

There were systems in place to ensure complaints were responded to appropriately. People could give feedback about the home online, however staff told us they felt this was not effective in capturing people's opinions of the quality of the service.

We received positive feedback about the manager, although some staff said they had not had the opportunity to meet her at the time we inspected. Staff were occasionally critical of the culture in the home, and told us they felt they were blamed for things which were not in their control. Staff did not have regular meetings, however the manager told us they would be addressing this.

There were governance systems in place, however they had not always identified issues which were picked up during our inspection. In addition the provider had not taken sufficient action to address breaches identified at our last inspection. We identified a continuing breach of regulations relating to governance.

We identified three continuing breaches and two new breaches of legislation during this inspection. You can see what action we have told the provider to take at the end of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

Risks associated with people's care and support were not always accurately documented.. Staff did not always know people's moving and handling needs, and we witnessed one serious incident during the inspection.

Staff recruitment was safely managed, however we found the provider had not taken sufficient action to ensure the numbers of staff on duty accurately reflected the dependency of people using the service..

Medicines were managed safely. Records showed people received the right medicines at the right time.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always receive regular supervision, although we found they received a good standard of training and an annual appraisal..

The provider recognised when applications for Deprivation of Liberty Safeguards (DoLS) were required, and ensured renewals were applied for in a timely way. We found consent was not always well documented, however..

Feedback about meals was variable, and we saw the provider had met with the company contracted to provide these with a view to improving quality.

Is the service caring?

Requires Improvement

The service was not always caring.

We found not enough had been done to improve the care experience of people who did not speak English, which was a finding at our last inspection.

People told us staff were caring, and we made observations on

both days of our inspection that evidenced this was the case.

Few people had advance plans in place which captured their wishes for end of life care.

Is the service responsive?

Requires Improvement

The service was not always responsive

Care plans were reviewed, with some involvement from people in the process. However, we found information relating to up to date needs was not always easy to locate in care plans.

We received mixed feedback about activities in the home. People we spoke with were more positive than staff, who felt more could be offered.

Is the service well-led?

Inadequate

The service was not well-led.

We received mainly positive feedback about the manager, who was in their induction period when we inspected, however staff said they did not know who the manager was.

There were audit and monitoring processes in place, however these were not always effective. We found breaches of regulation identified at our last inspection had not all been addressed.

Staff told us they felt limited in their ability to contribute ideas and suggestions to improve quality in the service. Some staff felt they were often blamed for things which were beyond their control.

Hemsworth Park

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 checked 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 took place on 23 and 25 May 2017. On the first day the inspection was unannounced and the team consisted of three adult social care inspectors and a medicines inspector. On the second day we gave the provider notice and the team consisted of two adult social care inspectors and an expert-by-experience with experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioning and safeguarding teams and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We had asked the provider to complete a provider information (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. This was sent to us in January 2017.

During the inspection we spoke with the home manager, deputy manager, regional manager, regional resident experience manager and a registered manager from one of the provider's other homes who was supporting the home manager during their induction. We also spoke with four unit managers, 13 staff care staff, activities staff and the chef. We spent time speaking with 17 people who used the service and 1 visiting relative. We also spoke with two visiting health professionals.

We looked at records relating to people's care and support including 14 care plans, medicines administration records, audits, accident and incident records, complaints and compliments, maintenance and recruitment. We looked at 11 staff recruitment records. We also spent time looking around all areas of the home including communal areas, bathrooms, toilets, some people's rooms and the kitchen.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in December 2015 we rated this key question as 'requires improvement.' We found recruitment practices and some aspects of medicines management were not always safe. We identified two breaches of regulations relating to safe care and treatment and staffing, and asked the provider to supply us with an action plan showing how improvements would be made. At this inspection we found the provider had followed their action plan and was now meeting the requirements of the regulations relating to medicines. However, we identified a new breach of regulations relating to safe care and treatment and concluded the provider remained in breach of the regulation relating to staffing.

People told us they felt safe living at Hemsworth Park. Comments included, "I feel safe, very safe," "I have never seen anything that I didn't like happen. It's a good home," and "I have never seen anything to make me feel unhappy." Relatives we spoke with told us they felt their family members were safe using the service. Our review of records relating to maintenance showed the provider ensured people were made safe through regular servicing and checks of equipment, and each person had a personalised evacuation plan for use in the event of an incident such as a fire.

We found some staff lacked awareness of the moving and handling needs of people. Staff we spoke with told us there were four people on the unit who needed two staff to help them move with the use of the stand aid equipment. Staff, including the unit manager, told us none of the people were routinely hoisted with a hoist and sling. We witnessed a serious moving and handling incident during our inspection. We saw one person begin to slip whilst being hoisted, and found staff were not using the correct sling. We spoke with the deputy manager after witnessing the incident. They told us staff should have known the person's correct moving and handling requirements as current information was available in a file in the person's room. When we checked this file we found it was not current and contradicted what was in the full care plan. The deputy manager told us there would be a meeting with the staff involved and further training provided. We asked for the incident to be reported to the safeguarding authority.

Care plans we looked at incorporated potential risks including those associated with falls, mobility, nutrition and hydration and skin integrity. However, we found risk was not always robustly assessed or managed, and there was a lack of guidance to show staff how care and support should be provided in order to minimise those risks. For example, one care plan we looked at stated the person was 'able to weight bear, but unable to walk.' We saw this person walking during the inspection. The same care plan also stated in relation to support when using the bath, 'Two staff members and use of bath hoist.' There was no information relating to a risk assessment relating to use of this equipment or guidance to show staff how the person should be supported safely.

Another care plan showed the person could at times become verbally and physically aggressive, however the care plan did not contain any information for staff other than a statement, 'Staff to be aware of de-escalation technique.' There was no guidance to alert staff to potential triggers for behaviours that challenged the service, or advice as to what suitable de-escalation techniques might be. This meant the person, staff and other people who used the service may have been at risk.

We concluded risks associated with people's care and support were not always safely managed, and this was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found there were not always enough staff. We asked people who used the service and their relatives about this and received mixed feedback. One person told us, "There are not enough day and night." Another person said, "I waited for two hours for help the other night." A relative told us, "In the day yes [there are enough staff], at night no, 20 mins is a long wait for them if they want to go to the toilet." Another relative said, "They are too rushed to sit and chat, I miss it."

Some people were more positive. One person said, "There are enough staff as far as I know." Another person told us, "There are enough [staff] most days and nights."

Some staff we spoke with told us they were concerned they could not always meet the needs of the people safely. Comments included, "We can't be in two places at once but we really try our best," "We have to ask residents to wait, that can lead to someone being incontinent and then they are embarrassed," and "It's just too busy for two staff. I know [the manager] is looking into it. We can't do all the paperwork and the care." This was not the case on all units we visited. Staff on one unit told us they felt staffing levels enabled them to meet people's needs.

A dependency tool was used to calculate staffing levels, and a review of rotas showed staffing levels had been at or above the level suggested by this tool. We discussed this with the management team, who told us they needed to review the dependency calculations to ensure these were correct. An extra member of staff was added to the numbers for night shifts following our inspection. Although we saw some action being taken as a result of issues we raised during the inspection, we had raised staffing levels as a concern at our last inspection, and identified this as a breach of regulations. We concluded the provider remained in breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We identified two concerns with the storage of medicines which were rectified during our inspection. Records showed one fridge was regularly getting too warm, and a replacement was ordered. Other records showed one medicines room was occasionally above the maximum recommended temperature for storage of medicines. The provider took action to move medicines to another storage room, and we were told air conditioning would be fitted before the storage room was returned to use.

Medicines were stored securely in a locked treatment room and access was restricted to authorised staff. There were appropriate arrangements in place for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse); they were stored in a controlled drugs cupboard, access to them was restricted and the keys held securely.

We checked the quantities and stocks of medicines supplied outside of the monitored dosage system for 12 people on four units and found the stock balances to be correct. Medicines administration records (MAR) had been completed fully to show the treatment people had received. People who were prescribed 'when required' medicines had protocols in place to guide care staff when and how to administer these medicines safely.

We looked at the recruitment files of 11 members of staff, and saw the provider followed a process which was safe. Files contained application forms, evidence of answers given at interview which showed the person's suitability for their role, background checks such as references from former employers, confirmation of identity and checks made with the Disclosure and Barring Service (DBS). The DBS is a

national agency which holds information about people who may be barred from working with vulnerable people. DBS checks help employers make safer recruitment decisions.

Staff said they had received training in safeguarding adults and had a satisfactory understanding of how to identify and act on allegations of abuse. They all said they were confident people were safe living in the service. Information on how to raise a safeguarding concern was on display in the home so staff could consult. Staff we spoke with said they felt confident in identifying the signs of possible abuse and would not hesitate to use the safeguarding or whistleblowing procedures, which they said they were aware of.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in December 2015 we rated this key question as 'requires improvement.' We saw moving and handling training had not always been kept up to date, and identified a need for improvement in the environment. Staff had not always received an annual appraisal, and we identified this as a breach of regulations. We also identified a breach of regulations relating to meeting people's nutritional needs, as we saw some people did not have adequate access to drinks throughout the day. We asked the provider to send an action plan to show how they would make improvements in these areas. At this inspection we found the approach to hydration and nutrition had improved, however staff were still not receiving adequate supervision. The provider remained in breach of this regulation.

We found supervision of staff had not always been kept up to date since our last inspection, however there was a plan in place to ensure this activity level was brought back into line with the provider's policy. Unit managers we spoke with confirmed action was being taken to ensure staff received effective supervision. We saw a matrix was in place which showed the manager was taking action to ensure staff received regular supervision in future.

We looked at records of staff supervisions and found their format did not evidence staff received support in relation to professional development. Staff told us receiving a supervision was more likely to be a reprimand for something not done correctly. For example, one staff member told us supervision was used, "To tell you off". They gave the example of group supervisions where everyone there would be told off for not completing paperwork correctly, although it might not apply to all the staff at the meeting.

Documents we saw supported this feedback. Sections for following up on objectives identified at earlier supervisions were usually left blank. Supervision records lacked evidence staff were encouraged to discuss their work and any training needs. Staff we spoke with told us discussions about work and training took place during their annual appraisal but did not routinely happen during the year.

We concluded the provider was not providing sufficient support for staff to ensure they remained effective in their roles, and this was a continuing breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they had confidence in the staff's ability to provide effective care and support. One person said, "They are good as carers."

Staff told us they felt they had received all the training they needed to carry out their job roles effectively, and could ask for additional training if they felt this was required. For example, one member of staff said they had asked for some behaviour management training and this had been approved. We reviewed records relating to training and saw this was up to date. The regional manager monitored training compliance levels within as part of their routine auditing of the service.

The unit manager told us the dementia framework was being implemented in the home and they were

awaiting accreditation for this. They said there had been in-house training in the areas of: observation; activities; reflective accounts/distressed reactions and communication and all staff had completed accredited e-learning in dementia care.

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).

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.

People told us they were able to make choices about their care, support and how they spent their days. One person said, "I make up my own mind about what I do, I call it the Motel." Another person told us, "I can decide to get up if I want to or stay in bed, I stay in my room and watch TV."

Staff said they had completed MCA training, and understood when people lacked capacity, decisions had to be made in their best interests. One member of staff said, "I can't make a choice for someone if they have capacity." Staff told us they had completed DoLS training and understood that these protected people. During the inspection we saw people being asked where they would like to sit, eat and would they like to take part in activities.

Staff could explain how to gain people's consent, including talking to family and the use of best interest meetings. However, this was not always clearly recorded in care files. We asked the unit manager on the residential unit to show us where someone who could be involved in planning their own care has signed to acknowledge they agreed with the planned care. They told us the person had been involved in the process but said they had refused to sign the plan. A discussion took place regarding staff recording the discussion with the service user and their refusal.

We found a lack of consent documentation in people's care plans, and where this was in place we saw repeated instances of staff signing to give consent, rather than the person or their representative. Some care plan agreements were left blank. This was a breach of Regulation 11 Need for Consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager had records which showed when applications for DoLS had been made, and when these had been authorised. Records showed the provider recognised when an application was required and monitored expiry dates to ensure re-authorisations were applied for in a timely way.

We received mixed feedback about the food served at Hemsworth Park. Staff we spoke with were not always complimentary about the quality, and said people often did not enjoy the meals. Staff on the Vale View unit, which was used by people living with dementia, said they had to ask people to make meal choices a day in advance, however they found people often struggled to make choices or, due to their illness, would not be able to recall what they had chosen.

People we spoke with, however, gave more positive feedback. This included, "It is all OK, the quality is OK and the choices are very good, "The food is excellent, I have no complaints," "The meals are on time," and "They will make you an alternative if you ask." People who required a specialised diet, for example to meet cultural or health needs, told us this was available for them. A small number of people gave more negative feedback. Comments included, "The food is rotten, quality is poor, fancy names for plain food," and "Sometimes good sometimes bad, the choice is poor only two things." We discussed the meal arrangements with the manager and resident experience manager. They told us they had met with the catering company who provided the meals at Hemsworth Park, and we saw records which confirmed this. They told us they were expecting to see improvements in the meals.

We saw people had good access to drinks during the day, although on the first day of our inspection we had to ask staff to get drinks for people on one unit. People were waiting for their breakfast to be served and told us they had not been offered a drink since getting up.

The cook told us staff completed a form when a new person moved into the home which was sent to the kitchen to make them aware of the person's individual needs and any special diet they needed. This also included their likes, dislikes, allergies and preferences. In the kitchen we saw information about people's individual needs and preferences were easily available to the kitchen staff.

We saw evidence in care plans that people were supported to access health and social care professionals when needed, although we saw some referrals which were not followed up when there was a delay in response. We saw people had access to a range of health care professionals including district nurses, the falls team and speech and language therapists. Both visiting health professionals we spoke with said they received timely referrals and their care advice was followed.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in December 2015 we rated this key question as 'requires improvement.' Staff did not always respond to people's needs, and staff could not communicate effectively with one person who did not speak English as a first language. We concluded this had a negative impact on their experience of care and identified a breach of regulation 10, relating to dignity and respect. We asked the provider to send an action plan to show how improvements would be made. At this inspection we found the provider remained in breach of this regulation.

Two people who used the service were Polish and did not speak any English. One person spent their time in their room due to illness, another had become withdrawn over time and no longer used the communal areas of the home. This person did not have support of family or friends. We were told one member of the domestic staff team could speak Polish, however other staff members could not. In one room a limited number of words and phrases had been translated and put on the wall, for example days of the week, months of the year and short sentences such as, '[name of person] is sad,' and '[name of person] wants to go home.' When we went to the person's room with a member of staff they told us, "We don't know how to pronounce those words."

One person's behaviour needs care plan stated, '[Name of person] can become distressed and aggressive towards staff and also to other service users. This is mainly when [name of person] does not understand what staff are saying to him or other service users due to communication barrier, and he then gets frustrated and angry.' There was no guidance to help staff communicate with the person, which would minimise the risks identified. For example, there were no suggested phrases for staff to use which may have enabled the person to engage with what was going on around them. Staff told us the person had become withdrawn and now chose to spend time in his room.

We concluded the provider remained in breach of Regulation 10 Dignity and respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did see other evidence of a positive response to diverse cultural needs. For example, we saw there were plans in place to support someone who wished to observe Ramadan. This included ensuring there was food available at appropriate times and consideration was given to monitoring their nutrition and hydration during this period. The person told us, "They are going to sort out special meals for me over Ramadan." The person also confirmed they received meals suitable for a halal diet.

People and their relatives told us staff were caring, and we made observations during our inspection which confirmed this. One person told us, "These lasses will do anything for you, they're good lasses. They're always so busy but they do what they can. They're lovely, I'm telling you, they do care about us". A relative we spoke with said, "The staff are very caring, always kind to [my family member] and I feel involved".

We saw staff interactions with people were patient and supportive overall. Staff greeted people by name and took time when supporting them with personal care, allowing people to set their own pace for conversation

and moving around the home. A member of staff said, "They're like my family, we spend a long time with people and we know them well".

We saw when some people felt confused, staff took time to reassure them and where people tried to explain things to staff, staff made every effort to understand the message behind what they were saying. Staff were very patient and listened attentively when people were repetitive in their conversation, and we observed friendly conversations between people and staff which people clearly enjoyed. Staff made regular checks of people when they were in their rooms and asked if they were alright.

Staff were respectful of people's dignity and discreetly asked if people needed support with personal care. People's independence was promoted well and staff involved them in discussions about the daily routine, such as when it would be lunch time and what was happening that day. When supporting people with moving and handling, staff gave reassurance and explained the process step by step.

The care workers we spoke with demonstrated a good knowledge of the people they supported, their needs and preferences. They described how the information in care plans, as well as the staff handovers, helped them find out about people needs and preferences, as well as changes in their wellbeing. We found little evidence of people's involvement in the writing of their care plans, however.

There was no one receiving end of life care at the time of our inspection, however care plans we looked at contained no information about people's advance wishes, sometimes known as end of life care plans. This meant if someone suddenly became seriously ill, staff would not always know how the person would want to be cared for. For example, some people may prefer to stay at Hemsworth Park for end of life care, rather than being transferred to a hospital or hospice.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in December 2016 we rated this key question as 'requires improvement.' We found some care plans lacked detail and were not always person centred. The provider had begun work on improving the quality of documentation in the care plans at that time, and we did not identify a breach of regulations in relation to this.

We observed a handover on the first day of our inspection. We saw this was informative and information shared about each person and how they had slept, or whether there were any matters to be particularly aware of. We also saw the communications book which gave key information about people's needs, such as if there were any appointments, visiting professionals, referrals required or concerns. The unit manager told us staff were reminded to be professional in what they recorded.

Staff told us they felt care files provided adequate information about people's needs. One member of staff described how care files were evaluated and updated on a monthly basis using 'resident of the day'. This meant that if someone was living in room one their file would be reviewed on the first day of the month and so on. They went on to explain that if someone's needs changed during the month the records should be updated as and when needed.

People told us about the process of reviewing care plans. One person said, "I am involved, they review it with me." Another person told us, "They have shown it to me and talked about it." A relative said, "Yes, I am involved in the reviews of [name of person]'s care plan."

We saw care plans were reviewed regularly, although details of any changes were recorded in the review sections; we did not see changes made to the care plan itself. This meant staff would need to read all the review updates to ensure they were aware of people's up to date care and support needs. We saw a number of reviews which just stated, 'no change to care plan', with no evidence of detailed reviews. We concluded documentation was not always person-centred, and raised this with the manager during feedback. We received an action plan after the inspection showing how improvements in this area would be made.

The majority of people we spoke with gave good feedback about activities in the home, and we saw this had been the subject of a recent online questionnaire. Information about the feedback and what had been done as a result was on display in the home. Staff we spoke with said they felt more could be done to ensure there were varied and engaging activities for people to join in with.

During our inspection we saw some activities taking place, including a quiz and a visit from a specialist fitness provider. On the second day of our inspection people told us they had expected the activities staff to go shopping for them, which would have been the normal routine. They told us this had been cancelled because of our visit. We asked the manager to act to ensure people were able to get their shopping.

We saw some care plans included information about people's interests, however this was not always used to ensure people were supported to maintain hobbies and interests. For example, we saw in one person's

care plan they enjoyed sewing, knitting and books, however we saw the person spent the day with little to do. We discussed the variable feedback with the manager. They told us they would do more to document people's interests and choices, and use this to ensure activities were more meaningful.

The provider had a complaints procedure which clearly outlined how concerns would be managed. It was easily available to people who lived and visited the home. Records showed that five concerns had been received since March 2016. The majority had been responded to appropriately and records outlined any action taken. This included letters sent to the complainant with the outcome of the manager's investigation. However, one concern would have benefited from more in-depth information about the source of the complaint, although it was obvious from the email on file that the concerns had been looked into and a response sent.

The people we spoke with told us they felt any concerns highlighted would be taken seriously by the management team and they would take action to address them. For instance, one relative said they had raised some issues about their relative's care with the new manager, and they had listened and been very responsive.

Where lessons had been learned from the complaints/concerns raised, or action had been taken, such as staff receiving additional support sessions, records showed that these had been followed through.

We also saw numerous compliments had been received in the form of cards, letters and verbal compliments.

One compliment dated December 2016 included, "You are a wonderful team and a very special bunch of people." It went on to say, "Thank you for all the care you showed our parents and the very thoughtful support you gave to us."

We asked staff how the company gained feedback from people using/visiting the service. They told us meetings were held approximately every 2 – 3 months and staff went round with an I-Pad asking people the set questions. The staff we spoke with about this subject felt the use of the I-Pad was not suitable. One care worker told us, "I don't like it; it's impersonal, better to have a chat and not ask the set questions." We gave feedback about this to the manager during our inspection. We discussed how they could improve engagement with staff.

Inadequate

Is the service well-led?

Our findings

At our last inspection in December we rated this key question as 'requires improvement.' We found the provider's quality monitoring systems had not identified and rectifed failings within the service, and we identified a breach of regulations relating to governance. We asked the provider to send us an action plan to show how improvements would be made. At this inspection we found the actions taken to improve quality monitoring had failed to identify required improvements, or deliver actions that were completed in line with the timescale identified. The provider remained in breach of the regulation related to governance, in addition to being in breach of other regulations identified in this report.

At this inspection we have rated the service as 'requires improvement' overall. This is the third consecutive inspection which has resulted in this overall rating for the service, which means we have not seen evidence of adequate leadership in place to ensure improvements are made or sustained. As a result we have rated this key question as 'inadequate'.

There was not a registered manager at the time of the inspection. There was manager in post who was planning to register with the CQC. They had been in post for three weeks. We discussed the gap between the previous registered manager leaving post in December 2016 and the present manager commencing in May 2017. The regional manager told us in this time candidates had been appointed but had either left after a short time or, in one case, had not taken up the post after it had been offered.

The manager was supported by a deputy manager, administrator, unit managers and regional manager. There was also a registered manager from another of the provider's homes giving support to the manager during their induction.

Staff who had met the new manager said they found her approachable and supportive, however we found some staff did not yet know who the manager was. We discussed this with the manager who said they planned to meet with all staff in the near future. One relative we spoke with said there had been a large turnover of registered managers, but told us they knew who managed the unit their relative lived on and found them approachable.

We received mixed feedback about the experience of working at Hemsworth Park. Some staff told us morale was good, and they enjoyed working at the service. One staff member said, "Really proud of staff team now. We have all worked really hard as a team now to improve the service." Another staff member told us, "I chose to work here as it's nice and friendly." We also received negative feedback. Some staff told us the number of managers in post in a short space of time had been disruptive and unsettling. They told us they supported each other but did not always feel well supported by the organisation they worked for. For example, a number of staff told us care staff often felt they were blamed for things which were beyond their control, for example lack of equipment and levels of staffing.

There were systems in place to measure, monitor and improve quality in the service, and we saw these were contributed to by unit managers, the home manager and the regional manager. There was a schedule of

audit in place which showed what was checked and at what frequency. These checks included infection control, mattresses, medication and accidents and incidents. The regional manager also performed a monthly audit on the service.
We saw medicines audits (checks) which had been developed since our previous inspection. These now included daily, weekly and monthly checks by staff and managers. Issues that had been identified had been acted upon and improvements made.

The audits were not always effective, however. For example, the issues with the medicines fridge and storage room had not been picked up, and we found some actions with a completion date before our inspection had not been addressed.

Staff told us they felt their ability to contribute to the running of the home was limited as there had not been general staff meetings during which they could make suggestions or discuss improvements with the manager. Staff we spoke with said they were encouraged to give feedback online, and told us they occasionally had meetings with their unit managers. We did see evidence of meetings held between management and the unit managers, however.
In line with regulatory requirements the provider had ensured their rating was displayed on the premises and on the website for the service.

There were repeat breaches and new breaches identified which the audit and governance activity had not been sufficiently robust to identify. We concluded the provider remained in breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent was not recorded in line with the requirements of the Mental Capacity Act 2005. Staff routinely signed consent documentation rather than the person using the service or their representative.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were in place but had failed to identify some issues which we saw at inspection. Insufficient action had been taken to ensure breaches of regulation identified at our last inspection were rectified.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Our observations and some feedback from people and staff identified staffing levels were not always adequate to meet people's care and support needs in an effective way. We also saw staff did not always receive supervision in a manner which supported them to remain effective in their roles.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect There was an on-going lack of support for service users who did not speak English. This had a negative impact on their experience of care and support at the service.

The enforcement action we took:

Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Information in care plans and associated documentation was not always accurate or up to date, and we saw a lack of guidance for staff to show how risks could be minimised. We observed a number of incidents which showed risk was not always managed robustly.

The enforcement action we took:

Warning notice