Solutions (Yorkshire) Limited

Harewood Court Nursing Home

Inspection report

89 Harehills Lane
Chappel Allerton
Leeds
West Yorkshire
LS7 4HA

Tel: 01132269380

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 29 November 2016, 1 and 7 December 2016. Days one and two were unannounced and day three was announced. At the last inspection in February 2016 we found the provider was in breach of four regulations related to medicines and the premises, the need for consent, person centred care and quality assurance. We also issued a fixed penalty notice as the provider did not have the current CQC rating of the home on display.

At this inspection in November/December 2016 we found the provider was still in breach of three of these regulations and was in breach of an additional two regulations related to staffing and fit and proper persons employed. The provider had made improvements in some areas; care plans were more informative on people's care needs and gave guidance for staff on care needs. The certificates to show the home was maintained safely were available and in date. We also saw the current CQC rating for the home was on display.

Harewood Court provides nursing and personal care for up to 40 people. The service is divided into two units with the second floor accommodating people who are living with dementia.

There was a registered manager in post. 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 and associated Regulations about how the service is run.

Medicines management was not safe and we found some issues we identified at our last inspection in February 2016 had not been addressed. This continued to put people at risk of not receiving their medication as prescribed.

One person told us there were not enough staff and one person said staff did not come when they needed them. They also said they sometimes received their medication late. We found people were not always cared for, or supported by, enough skilled and experienced staff to meet their needs. There was only one nurse on duty at all times; to cover two floors of the home. The registered manager calculated staffing requirements on people's level of funding and not their individual assessed needs.

Recruitment procedures were in place. However, for one staff member we found their Disclosure and Barring Service (DBS) check had not been checked for their employment at this home. The DBS checks assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people. For another staff member, their DBS had an error within it which could have affected the validity of the DBS.

The provider's disciplinary procedures had not always been followed when concerns had been raised about staff member's fitness and ability to carry out their duties. Systems in place were not robust and records did

not clearly show the actions taken in these circumstances to ensure staff's practice was safe.

Care plans we looked at contained risk assessments associated with people's care and support needs which staff understood and followed to keep people safe. We saw there was a positive atmosphere in the service and people who used the service had developed good relationships with the staff team. Staff could recognise abuse and knew what action to take to ensure people's safety.

We found the service was not fully meeting the legal requirements relating to the Mental Capacity Act 2005 (MCA) and these were the same concerns we raised at our inspection in February 2016. Mental capacity assessments were not specific to the decisions being assessed and there was conflicting information within capacity assessments which made it unclear as to whether people had capacity to make their own decisions. Mental capacity assessments undertaken were confusing and contradictory and showed a lack of understanding of the principles of the MCA.

Where people lacked capacity, relatives, staff and other health and social care professionals were not always consulted and involved in making decisions in each person's 'best interest'.

Deprivation of Liberty Safeguards (DoLS) records showed two people's had expired and applications for renewal had not been made until after the expired date. There was a risk people could be being deprived of their liberty illegally.

Overall, we saw staff training was updated regularly. However, records showed some staff had not completed training in MCA and one of these staff had completed a number of the MCA assessments where we saw there were shortfalls. Nursing staff had not all received a check of their competence to administer medication. Staff had regular supervision; however, this was not a two way process of communication between the supervisor and the person being supervised.

People were supported to eat and drink well and to maintain a varied balanced diet of their choice. Culturally appropriate food was provided for people; with a twice weekly Caribbean option on offer.

Overall, people had access to healthcare facilities and support that met their needs. However, we found the instructions of a health professional had been overlooked for a number of months which put the person's health at risk and for another person the instructions had not been transferred in to the person's care plan.

People received support from staff who knew them well. People's dignity and privacy was, in the main, respected. Care records showed people's needs were identified and responded to in a person centred way. Information was written in a person-centred way. However, daily notes were not completed in detail to show how people spent their day.

There were procedures in place to ensure the provider responded appropriately to any complaints they received and information was displayed about how people could make formal complaints.

People were provided with a range of activity within the home and most people we spoke with said they were satisfied with this. However, we saw there were times when people received no interaction and stimulation and were falling asleep; sometimes in uncomfortable positions.

Staff spoke positively about the registered manager. They said they were approachable and communicated well on the needs of the service and what was expected of staff.

There were systems in place to monitor the quality and safety of the service provided. However, these were not fully effective. Actions to improve the service were sometimes identified but then not followed up and addressed. The audits used had failed to highlight any of the concerns and discrepancies we found at this inspection.

We found shortfalls in the care and service provided to people. We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's 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.

People who used the service were not protected against the risks associated with the administration, use and management of medicines.

There were insufficient staff deployed to meet people's needs.

Recruitment procedures and systems in place to ensure any concerns raised about staff's fitness and ability to carry out their role were not robust.

Is the service effective?

Inadequate

The service was not effective.

Key requirements of the Mental Capacity Act 2005 were not fully understood and Deprivation of Liberty Safeguards (DoLS) records showed some people's had expired and applications for renewal had not been made until after the expired date.

Staff were not always trained to carry out their roles and responsibilities appropriately.

Systems in place to ensure people's healthcare needs were met were not well organised and robust enough.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We saw people's confidentiality was not always respected.

Records showed limited involvement in the care planning process from people who used the service or their relatives.

Staff had developed good relationships with the people who used the service and there was a happy, relaxed atmosphere.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Daily records for people who used the service were not completed in detail to show how people spent their day.

There was a system in place to record, investigate and respond to complaints.

People enjoyed a range of social activities; there was a programme of activity for people to join in with, although we saw there was a lack of social interaction and stimulation for some people.

Is the service well-led?

Inadequate

The service was not well- led.

The provider did not take appropriate action to meet regulations following the last CQC inspection. Issues we identified had not been resolved.

Quality management systems in place were not effective as information was not fully analysed and used to create meaningful action plans and improvements.

Harewood Court Nursing Home

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 took place over three days on 29 November, 1 and 7 December 2016. Day one and two were unannounced; day three was announced to ensure the availability of the registered manager. On day one an adult social care inspector and a pharmacist inspector attended. On day two, two adult social care inspectors and an expert by experience attended. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On day three, two adult social care inspectors attended.

At the time of our inspection there were 36 people using the service. During our visit we spoke with seven people who used the service, three relatives, three care staff, one nurse, the activites co-ordinator the deputy manager and the registered manager. We spent time looking at documents and records related to people's care and the management of the service. We looked at six people's care records and 19 people's medication records.

We met most of the people who lived at the service; some of them were living with dementia and were unable to communicate their experience of living at the home in detail. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Before the inspection providers are asked to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and

improvements they plan to make. We used this information to help us plan our inspection.

We also reviewed all the information we held about the home, including previous inspection reports and statutory notifications. A statutory notification contains information relating to significant events that the provider must send to us as required by law. We contacted the local authority 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.

Inadequate

Is the service safe?

Our findings

At our previous inspection in February 2016 we rated this key question as requires improvement. We found medicines were not managed safely and people were not protected against the risk of not receiving their medication as prescribed.

We saw that not everyone had an adequate supply of medication which meant that they could have the doses of their medicines as prescribed. We saw that one person could not have two of their medicines for five days because one of their medicines had run out and the nurses had failed to ensure there was sufficient equipment available to administer the second medication. Another person's records showed they had no stock of analgesia (Paracetomol and codeine) in the home on the first day of the inspection. This placed people's health at risk of harm.

We saw that people were not always given their medicines safely. When we compared the stock of medicines in the home with the records we found some medicines had not been given because the stock levels were higher than expected for some medicines and stock levels were lower than expected for other medicines, which meant that not all medication could be accounted for.

Most medication which needed to be given before food was given at the correct time, however we saw that some people were prescribed medicines to be given in this way were given them with their breakfast. This meant that those medicines may not be effective. Medicines containing Paracetamol must be given with a minimum of four hours between doses; one person was given doses of Paracetamol too close together the day before the first day of our inspection. We also saw when people had four doses of Paracetamol throughout the day, nurses did not record the time so could not show that they doses had been given safely. Some people needed to be given their medicines covertly, by hiding their medication in food or drink. However we saw that nurses either failed to follow the pharmacist's advice as one nurse told us they did not follow the advice in the pharmacist's letter and medication was crushed without knowing if this was safe or had not obtained full information and they had failed to develop a care plan for administering medication covertly.

We saw that for some people the information recorded to guide staff when administering medicines which were prescribed to be given "when required" was missing or lacking in sufficient detail to ensure people were given their medication appropriately. There was no information available to guide nurses which dose to select when a choice of dose was prescribed. We also saw that there was no information available to guide nurses to help them decide when to commence administration of medication (anticipatory drugs), used when people were very poorly. If this information is missing medicines may not be given effectively or consistently and people's health could be at risk or people may be in unnecessary discomfort.

Information about how and where to apply creams was not always available to care staff, which meant they may not be applied properly or consistently. We saw some records which showed they had been applied, but we found some people had creams in their rooms and there were no records to show they had been used as prescribed.

Some people were prescribed thickeners to make sure they could have drinks without choking. We found that staff who prepared and served drinks did not have detailed written guidance as to how to thicken people's drinks to the correct thickness. Care staff had to rely on their memories to remember how to thicken each person's drinks, which is unsafe practice. We looked for the information about thickeners for five people and could only find written information in current care files for two of those people. The nurse on duty was not always sure how much thickener was needed to ensure people's drinks were safe. Care staff told us that they did no't make any records when they thickened people's drinks.

Records about medicines could not always show that medicines were given safely as prescribed. On the first day of inspection we saw that the nurse did not sign the records of administration for one person until some hours after the medicines had been administered. The nurse also signed for one person's medication they had given the day before. Records must be signed at the time of administration so that the records are accurate and nurses do not have to rely on their memories. We also found that some staff were ticking they had given medication instead of signing for it.

We reviewed the medication administration records (MAR's) for 19 people, and found these records did not always have 'front sheets' which detailed important information including preferences as to how the person wished to take their medication, a photograph and information about any allergies. This meant that if a new member of staff or an agency worker administered medicines they may have difficulty in identifying people and their preferences.

Medicines were not always stored safely. Prescribed creams were being stored in people's rooms, however the provider had not considered the risks associated with this; the registered manager told us no risk assessments had been completed or considered. We found the creams were not stored securely and therefore there was a risk that these medications were accessible to unauthorised people. We also saw that a bottle of Morphine liquid was out of date, which meant it may not have been effective in relieving pain if pain relief was needed. Tins of thickeners were left on an unattended tea trolley in the dining room. In February 2015 a patient safely alert was issued regarding the need to keep the thickening powder out of people's reach to avoid accidental asphyxiation if it was inadvertently swallowed. By failing to follow the advice in the safety alert, people were placed at risk of harm.

We examined the provider's medicines policy and found that it was limited in scope and did not always provide nurses with clear guidance on various aspects of safe management of medicines. Where guidance was provided we found nurses did not always follow it, which could place people's health at risk of harm.

This was a breach of Regulation 12 (1) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider did not ensure that nurses followed the systems in place to manage medicines safely.

One person who used the service told us there were not enough staff to meet their needs. Another person said staff did not come when they needed them. A relative told us they thought staff were always stretched and busy. We saw staff were actively responding to people and their requests for assistance when buzzers sounded. However, staff did not have time to interact and chat with people for any length of time and most interactions were task orientated.

Our observations showed there were periods of time when people who used the service were not supervised in the communal areas. During these times we saw people were asleep or left sat in wheelchairs rather than armchairs which placed their comfort and safety at risk. One person told us they were uncomfortable on a number of occasions and we had to find staff to attend to them and ask that they be transferred to a

comfortable chair.

The registered manager told us there was one nurse available to cover both floors of the home 24 hours per day. In addition to this they said there were one senior care worker and three care staff on the first floor of the home and on the second floor there were one senior care worker and two care staff available 8am-8pm. They also said that at night there was one nurse and three care workers available for the whole home. We reviewed the rotas for a four week period and saw that on 9 out of 28 days there was a shortage of care staff from what was planned.

We observed that with one nurse available to cover the whole home, the time taken to administer medication meant nursing hours were reduced and there was limited time available for completion of other documentation and following up on issues such as guidance from health professionals. This was evident from our findings regarding the shortfalls with medication. A nurse we spoke with said it was difficult to manage as there was only one nurse on duty to cover two floors of the home. They told us it was hard to attend to everyone's medication in a timely manner, complete dressings and accompany doctors on visits at the home. They said there was a lot to do and not enough time to review documentation such as care plans and risk assessments. They said, "Everything is on me. No other nurse when I am here, no time to discuss clinical issues. [I] just can't manage in the duty hours." They told us they rarely got an uninterrupted break in their 12 hour shift. They said, "I would have to be called from my break, leave my food and run to attend to things."

Two staff we spoke with said they felt there were enough staff to meet people's needs. However, one staff member said, "You always say you need more staff. There will always be some waiting time, it doesn't matter how many staff there are. We have one nurse, we can always find them. If we need them and if they are on a break they have to come."

The registered manager told us they used a dependency tool to calculate the staffing requirements of the home. They said this was based on people's funded hours, occupancy and not on individual needs. The tool did not take into consideration any individual aspects of dependency such as assistance needed with eating/drinking, continence, communication, mobility or social needs. The latest dependency tool available showed that there were 37 people with nursing needs of which nine were high dependency funded. There was no other information to show what had been assessed or considered.

We therefore concluded appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified and skilled and experience staff to meet people's health and welfare needs had not been taken. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment and selection processes in place. For most staff appropriate checks were undertaken before staff began work, this included records of Disclosure and Barring Service (DBS) checks. The DBS checks assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people. However, we found for one staff member they had commenced work at the home with a DBS carried out by a previous employer. The registered manager said an up to date online check had been done prior to this staff member commencing work at the home. There were no records of this available. For another staff member we noted on their DBS that their gender had been recorded wrongly. This had not been picked up by the registered manager and could have affected the validity of the DBS. We concluded that recruitment procedures were not fully effective to protect people who used the service.

We saw there were incidents were concerns had been raised by staff and the registered manager about staff's fitness and ability to carry out their roles. Records we looked at did not always show how the provider's disciplinary procedures had been followed when these concerns were raised and what had been put in place to ensure any risks to people who used the service were minimised. For example, we saw a memo written to a staff member about concerns with their medication administration practice had not been followed up with the action taken in order to prevent re-occurrence and ensure safe practice. We saw a staff meeting showed allegations of sleeping on night duty had been discussed with the staff team. There were no records of the action taken in response to this to protect people from the risks associated with the allegations.

We concluded the above evidence demonstrated a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service told us they felt safe. One person said, "The staff are very kind and wouldn't put me down." Another person said, "It's nice here, people are friendly and I have a good time." A third person said, "The staff treat me well." Three relatives told us their family members were safe at the home. One relative said, "The staff are very caring, I have observed the interpersonal interactions, and the relationship between staff and residents is very good, I feel the staff genuinely care and are not just pretending to do so." Two people told us they did not always feel safe as they had concerns about access issues at the front door and told us the lights are turned off early at night. We passed these concerns on to the registered manager who said they would be investigated. One person told us they liked a staff member and then said this staff member was bossy and had slapped their legs. We passed these concerns on to the registered manager who confirmed previous allegations had been made by this person. They said they had been investigated and were unsubstantiated. However, the registered manager referred the concerns we raised to the local safeguarding authority for investigation. The action taken by the registered manager was in accordance with the provider's safeguarding policy.

We found the service had safeguarding policies and procedures in place to inform staff of what constituted abuse or when and how to report any incidents. Staff were able to describe different types of abuse and were clear on how to report concerns outside of the service if they needed to; this is known as whistleblowing. Staff told us they were confident action would be taken if they reported any concerns. Care plans we looked at contained risk assessments associated with people's care and support needs. These included documentation relating to risks of falls, pressure sores, nutrition and hydration, choking and contractures. The risk assessments were updated monthly. We saw measures which were in place to minimise the risk were noted in the risk assessment and associated support plan.

We carried out an inspection of the premises and some of the equipment used in the home. We saw the home was clean and homely. We noted one of the bathrooms in the home was used for storage of wheelchairs, walking frames and commodes. This made the room very cluttered and posed a hazard to people who used the service. The registered manager said this should not have occurred and made immediate arrangements for alternative storage to be found. We also saw the lighting in the first floor sitting room was very dull; which could also pose a hazard and add to risks of falls and brought this to the attention of the registered manager

The registered manager ensured the maintenance of the building was kept up to date. We saw regular testing and servicing including checks on fire alarm systems, electrical and gas installations and equipment used in the delivery of care and support including hoists and wheelchairs. The fire evacuation plan contained information which showed the level of support each person needed in order to be assisted to leave the building safely in the event of a fire. We looked at records of call bell tests, and saw these were

carried out on a regular basis.

Inadequate

Is the service effective?

Our findings

At our last inspection in February 2016 we rated this key question as inadequate. We found the provider was not fully meeting the requirements of the Mental Capacity Act 2005 (MCA). We saw assessments of people's capacity were not specific to the decisions being assessed, and asked the provider to submit an action plan to show how they planned to make improvements to this. At this inspection concerns remained.

"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.

Care plans contained assessments of people's capacity to make decisions, however it was not clear what decision was being assessed. For example, one capacity assessment stated, '[Name of person] has a lack of capacity due to Alzheimer's and short term memory. Staff to assist [name of person] with mobility due to her hip as she uses a full hoist and sling for all transfers. Qualified nurse to administer all medications.' A series of questions was used to assess the person's capacity. The assessment recorded the person was not able to retain the information long enough to make a decision. However, the assessment also recorded the person was able to understand the information, use the information as part of the process to make a decision, and had capacity to make the decision. Notes alongside the conclusions stated, 'non-complex information only'. The person's 'How to keep me and others safe' care plan stated, 'I lack capacity.' There was no information to guide staff to which decisions the person could or could not make. This approach to capacity assessment was seen in all care plans we looked at.

The same person's care plan contained a best interest's decision record; however this was also not specific. Wording used was repeated in a number of best interest's decisions. It stated, '[Name of person] is dependent on staff for all ADLsn due to her [sentence unfinished]. [Name of person] has no health awareness or safety awareness. She is unable to answer complex questions or make complex decisions.' This did not indicate which decisions the person could make independently or with appropriate support. The best interest decision record listed 'DoLS', 'Nursing Staff' and 'GP' as having been involved, but there was no indication of their views and input.

In one person's care plan we saw a mental capacity assessment dated 8 March 2016. Included in the narrative for the decision being assessed we saw the statement, 'Covert medication is in place.' The capacity assessment stated the person could understand the information, and communicate their decision. The member of staff completing the assessment had added 'often not in his best interests' after indicating the

person could communicate their decision. The assessment concluded the person did not have capacity despite stating they could understand and communicate their decision.

We saw one member of staff had signed that they had completed a number of capacity assessment and best interests decision documentation, although the training matrix showed they had received no training in this area from the provider. We asked the registered manager how they had known the staff member was competent to carry out this role. They told us they had said in their interview they had had training in MCA, and we saw interview records which confirmed this. We were also given a copy of the staff member's training certificate for 'Dementia awareness and person centred care, Safeguarding, DoLS and mental capacity' completed in October 2016. However, this was after the date on the capacity assessments they had carried out.

Some people were receiving their medicines covertly. This meant they were not aware that some of their food or drink contained medicines. We saw capacity assessments had been carried out, however these did not show the person lacked capacity to decide if they wished to take their medicines. In one person's care plan we saw a capacity assessment had been amended by hand to state the person was, 'now on covert meds due to refusals.' A best interest's decision dated stated, '[Name of person] is on covert medications', although we did not see a best interest's decision or input from health professionals relating to this. The covert administration form in the person's care plan was dated 26 August 2016. This contained advice from the person's GP dated 4 October 2016 which stated, 'Diagnosis of dementia, needs on-going medication.' This did not state that any medicines should be given covertly.

We asked a nurse about one person's covert medicines. They told us the person's medicines had all been stopped by their GP, however there was no correspondence to show us when or how this decision had been made, and no related best interest's decision. We saw notes in the person's care plans which showed the service was still requesting creams for application to the person's skin, although the nurse said these were not being applied. They told us, "[Name of person] is not on any medication. We asked the doctor and they took them away. We have covert medicines in place in case they need them in the future. For an infection, that kind of thing." The best interest's decision had not been made for any anticipatory need. The covert administration form in the person's care plan stated, '[Name of person] has a skin issue underneath her bosom that is not improving due to refusals of cream administration and the administration of oral medication.' We saw entries in the health professionals record in the person's care plan that staff had spoken with the person's GP about ordering creams for their skin in November 2016, which contradicted what the nurse told us.

There was limited evidence the provider had obtained consent from people, for example for their residence, administration of medicines or to have photographs taken. The registered manager told us, "People or their relatives sign the care plans", however there was no guidance printed on the care plan that informed people they were giving consent to the contents. Some people's care plans had signatures on the front cover to show they or their representative had given consent for health professionals to access the information, however this was inconsistent. Similarly some consents had been signed for photography. We did not see consents for people living at Harewood Court or having medicines administered.

We saw records which showed which people had a DoLS in place, when these were due to expire and when a renewal request had been submitted. Two renewals had not been submitted in a timely way. One person had a DoLS in place which expired on 28 October 2016. The records showed the renewal had been submitted on 21 November 2016. Another showed an expiry date of 19 June 2016, and there was no information as to when the renewal request had been sent. This meant there was a risk people could be being deprived of their liberty illegally. We looked at the provider's policy relating to DoLS, dated November

2016. This referred to 'Deprivation of Civil Liberties', meaning the provider was using an incorrect name for the legislation.

Staff we spoke with said they had completed MCA and DoLS training. Staff had knowledge of the MCA and understood their responsibilities to respect people's rights to make their own decisions when they could. However, staff we spoke with did not know who had a DoLS in place in the home. They said they would have to look this up or ask the registered manager. Records we looked at also showed that some staff still needed to complete MCA training.

We concluded there was a continued breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as records demonstrated that key requirements of the Mental Capacity Act 2005 were not fully understood and Deprivation of Liberty Safeguards (DoLS) records showed some people's had expired and applications for renewal had not been made until after the expired date.

We saw records which showed people were supported to access a range of health professionals when this was needed. These included GPs, speech and language specialists, opticians, dentists and community nursing teams. We saw in one care plan that a concern had been expressed by the person's relatives about their oral health. We saw staff had contacted a domiciliary dentist service and arranged for them to come and treat the person's teeth. However, some information provided by health professionals had not been transferred into the relevant care plans. For example, we saw a letter from a speech and language therapist dated 10 November 2016. This contained specific recommendations for staff to follow in order to provide effective care for the person. Their care plan had been reviewed on 20 November 2016 however these recommendations had not been incorporated into the relevant guidance for staff, which meant these needs could be overlooked. We also identified through our review of medicines that a person who used the service had had some changes made to their health support by a speech and language therapist and this had been overlooked for eight months.

We saw care plans contained risk assessments and monitoring tools to ensure any risks associated with nutrition were identified and acted on in a timely way. We saw people's weights were recorded monthly and a Malnutrition Universal Screening Tool (MUST) was used to monitor their nutritional well-being.

There was a mixed response to the food at the service from the people living there, most thought it was good, one person told us "The food here is very good, there is plenty of it, they are very generous with seconds", another said "The food is nice and there is plenty of variety." We spoke to one person who told us, "The food dries out and you don't get a choice and they have cheap Cornish pasties" but they also told us they do offer an alternative if they wanted one and we observed this was the case during lunch time. Two of the relatives we spoke to said the food was very good and lunch looked very nice.

The menus changed on a seasonal basis. There was a four week menu plan which was varied and also catered for some Afro-Caribbean tastes. During the inspection we observed lunch in both dining rooms of the home. The atmosphere was relaxed with music playing and people were socialising with each other and interacting with staff. We saw staff encouraged and supported people to eat their meals. People were offered alternatives if they did not want what was on the menu. Staff took their time with people and no one was rushed.

Staff told us the training they received provided them with the skills and knowledge to carry out their job well. One member of staff said, "It's really good training and refreshers are always done." They also said they felt the provider gave them opportunities to develop themselves by undertaking further training such as

vocational courses and team leader training. Another staff member said their induction had made them look forward to working with people living with dementia. They said, "It's great training, very good, gives you knowledge, always something to learn." We looked at training records which showed staff had completed a range of training courses including moving and handling, safeguarding, dementia and challenging behaviour and person centred care.

Staff we spoke with said they were well supported by the registered manager and they received regular supervision to discuss their role and responsibilities. However, a nurse we spoke with said they had expressed concerns to the registered manager about working as a sole nurse on duty in the home, and these concerns had not been addressed. We looked at records of some staff's supervision meetings and saw these did not indicate that supervision was a two way supportive process as there were no comments from the staff member being supervised. Records showed that themed supervisions took place with each person having the same issues documented. There was no evidence to show how staff had reflected on the themes or been able to discuss how practice and development would improve as a result of their supervision. One staff member could not tell us how often they had supervision and told us they sometimes had them without any notice. This meant staff would not be able to prepare for their supervision meetings.

Requires Improvement

Is the service caring?

Our findings

There was some evidence people's dignity and rights had been considered when writing their care plans. For example, one person's care plan for 'how I make my wishes known' contained the following guidance for staff. 'When speaking to me please face me so that I can try to read your body language. Although I am unable to effectively communicate with you I may still understand what you say, so explain what it is you are going to do for me.' However, our findings regarding mental capacity assessments did not show that people's rights had been respected.

Care plans we looked at contained risk assessments and guidance written in the first person, which showed the information was specific to each person and based on a knowledge of them and their wishes. Information was written in a person-centred and caring way. For example, the guidance in one person's care plan stated, 'If I prefer to stay in bed or I don't appear well enough, let me have a day in bed, but come and visit me so that I don't feel forgotten.' Some care plans contained information about people's lives, likes and dislikes. This was in a document called 'living eulogy'.

We observed staff treating people sensitively and with patience; they all got down to people's level when helping them and gave explanations of any interactions. Two people had sight problems and staff explained exactly what was on their plate when they were having their meal. One person became distressed and staff responded well; asking the person calmly if they could help and tried to find out the cause of the distress for the person. At times staff had to wipe food from people's mouths and did so gently and explained what they were going to do. However, they did not check with people that it was okay with them. We also saw the nurse talked to one person about a conversation they had had with this person's GP about their medication in front of everyone in the dining room which did not show respect for that person's privacy.

People said they were well cared for. They said they felt they were treated with respect and dignity. We spoke to one person who needed full support with personal care and they said they were always shown kind consideration when staff were helping them. They said staff used the hoist well when moving and handling them and were patient. Another person we spoke with told us, "I get washed every day and they are very gentle with me." We spoke with another person who told us, "Staff let me choose what I want to wear every morning and I can have a shower or a bath whenever I want to." Another person told us that before helping with personal care staff always asked for the person's permission. Other comments from people who used the service included; "I am very happy here miss, very well looked after thank you" and "They are all so kind, look after us well, couldn't be happier here."

People who used the service were all well-groomed and appeared well cared for which is achieved through good care standards. We spoke to one relative whose family member used to live in the home but had passed away. Another family member was still living at the home and they said the staff had been very good in supporting this family member with the bereavement. They said, The staff have been fantastic with my [family member], very caring." Another relative told us, "Staff are very gentle with agitated people."

During the inspection when we observed staff spending time with people it was clear they knew the people

they were supporting. Staff were able to tell us about people's history, likes and preferences; such as an interest in music or their favourite foods.

Staff told us people were well cared for and the registered manager and provider expected them to provide high standards of care. Staff told us they enjoyed being able to care for people. One staff member said, "I love looking after people, supporting them, hearing people's stories and giving them a better quality of life. I wish I could make them all better." Staff gave good explanations about how to respect people's privacy and dignity, and told us they understood how to put this into practice. We saw care staff respected people's privacy and dignity when they were supporting people with personal care such as moving and handling.

The registered manager told us they contacted advocacy services for people if they thought it may be beneficial. We saw information on advocacy services was on display in the home so people who used the service could access this information.

Requires Improvement

Is the service responsive?

Our findings

There were times when we observed people who used the service were sat in the lounge with very little stimulation. On the first day of our inspection we saw there was no organised activity at any point of the day. In one of the lounges we saw at times people were placed in front of the television in chairs when they were asleep or positioned in chairs where they were unable to see the television.

Most of the people we spoke with were aware of the activities available in the home and thought there were things to do. However, some thought there was not enough to do. We saw there were two activity files; one for each floor in the home. There was a list of people's birthdays and an individual 'Lifestyle passport' for each person which had a list of activities people were interested in filled in for each person. For example, one person liked to do household chores and helped with the dusting. They told us they helped around the home and were very pleased about this.

On the second floor there was a corridor designated 'Memory Lane' which had old movie photos and other memorabilia including a washing line with clothes hanging on. There were a number of people living in the home who were of Afro-Caribbean origin and the conservatory was decorated in recognition of this.

There was a list of activities in the file and on noticeboards on both floors. Five days a week there were two activities each day which alternated between floors weekly, the other days there was just one event which took place on the different floors of the home on a fortnightly basis. Activities included music, sing songs, films, exercises, quizzes, bingo, pamper days and additionally every six weeks an outside organisation came in to do exercises designed for the people living at the home. During the summer there were outings and on each floor there were photographs of these events such as visits to places of interest. We spoke with a music therapist who was providing an activity at the home. They said how much they enjoyed coming to the home and found the staff enthusiastic in their participation with people who used the service. They said, "I love coming here, it's always so lively and people have fun."

The activity co-ordinator told us people who used the service enjoyed visits from people who brought dogs. They told us they were currently sourcing a dog to visit as this was always such a popular activity. We observed the music activity on the second floor in the morning of our second day of the inspection; staff were fully involved and most of the people were engaged in the activity, it was a very lively affair.

Records showed people had their needs assessed before they moved into the service. This ensured the service was able to meet the needs of people they were planning to admit to the home. The registered manager said assessments were carried out initially by the registered manager or deputy manager and nursing needs were discussed and assessed with nursing staff.

Care plans were developed from the initial assessment of needs, and risks were also identified. Care plans showed they were reviewed regularly and we saw some evidence to show the provider involved people and their relatives in the process. We saw one care plan which contained a review signed by members of the person's family. We spoke with two relatives who told us they were fully involved in developing a life map for

their family member and felt they could influence change. An example they gave was that their family member liked to sit quietly but the home did not have a quiet room, so staff put two armchairs in the dining room which resolved the situation. We saw care plans contained daily notes, however these followed a repetitive format and did not evidence in detail how people had spent their days.

People said they were generally very happy with the staff at the home but most could not recall if they had a care plan and no one could recall if they had a keyworker. Two people did recall they had a care plan. People told us staff were responsive to their needs. One person said, "If I am poorly, I don't have to wait, they see what I want and get it for me." People told us they could follow their own routines such as when to get up and when to go to bed. A staff member said, "Everything here is about the residents and what they want; if they want a lie in they have one, if they want to eat in their room they do." We observed staff responding to people's requests and helping to calm those who were distressed.

We saw there were systems in place to deal with concerns and complaints, which included providing people with information about the complaints process. We looked at records of complaints and it was clear people had their concerns, complaints and comments listened to and acted upon. We saw the complaints procedure was on display in the home. We noted the complaints procedure did not give the contact details of the local authority to enable people to use this route to raise or escalate their concerns. The registered manager did not have a system in place to analyse complaints to see if patterns or trends were identified. They told us "I just know what we have and act on them." This approach meant that over time, important areas of risk may not be picked up and addressed.

The registered manager also maintained a log of compliments received at the home and we saw there were frequent comments from family members of people who used the service about the caring nature of staff and the quality of care provided.

Inadequate

Is the service well-led?

Our findings

At our last inspection in February 2016 we rated this key question as requires improvement. We found the provider had a system of audit in place but these audits had failed to identify the concerns we identified with MCA's, medicines and care plans. We found at this inspection the care plans had improved; they were more person centred and identified how people wished to be cared for. However, our concerns regarding MCA's and medicines remained and had not been identified through any effective system of audit by the provider. The systems in place were not robust enough to ensure continuous improvement in the service.

We looked at medication audits and saw that at times these were difficult to read and understand, and did not identify whose medication and records had been checked. Actions identified were not clear and did not relate to findings. Some of the audits we looked at were not completed in full with many areas of the audit missed out. This included checks on controlled drugs, storage, fridge temperatures and PRN protocols. Other medication audits showed 'anomalies' were identified but did not list what these were, therefore no action was taken in response to them. Three audits that had taken place since our last inspection had failed to identify any concerns regarding medication yet we saw other documentation which showed concerns had been raised in that time frame. Audits had not identified that only one of four nursing staff had received an annual competency check on medication. We concluded medication audits were not effective in identifying concerns and ensuring improvements were made. The audit used had failed to highlight any of the concerns and discrepancies we found. Where issues had been identified, we were not able to see exactly how these issues had been addressed.

After the last inspection the provider told us in their action plan they would be reviewing all the files of people who used the service to ensure the MCA was complied with, and an audit would be carried out by the provider in August 2016. We asked to see evidence of this audit. The registered manager told us this was done as part of the care plan audits. We looked at some of these audits and saw in September 2016 two people's records were audited. No concerns regarding MCA and DoLS were found. This audit was difficult to decipher as it had been done on two people's records but did not refer to individual's information for these people. In August 2016 and June 2016, six people's MCA and DoLS documentation had been checked. No actions were raised on the need to improve any of these. This was not consistent with our findings and we therefore concluded these audits were not effective.

We looked at records of support visits carried out by the operation's manager in October and November 2016. Areas reviewed included the environment, the costed rota, an incident record, a complaint, activities and cleaning. Urgent DoLS were applied for and a nurse was spoken with about a care plan. None of the records were detailed and did not show which records were reviewed or which staff were spoken to. This was not an effective review of the service and did not detail any findings.

We were told by the registered manager that the provider visited the service frequently. However, they said there was not a formal record of this. We were told any checks on the home completed by the provider were then discussed in supervision with the registered manager. The registered manager showed us some recent supervision records. In September 2016 the provider gave feedback on care plan audits with reference to

MCA's. They said, 'they were relatively good and decision specific with a regard to capacity and there was clearly an understanding of this by the author.' This was not consistent with our findings at this inspection. The registered manager also showed us an action plan titled 'Annual combined/rolling and current action plan 2016-17'. There was no other date on it. Where actions were recorded as required it was not always clear what the actual actions were or how and when they had been identified.

There was a registered manager in post who had been registered with the CQC after the last inspection of the service. The registered manager told us of the systems in place to cover any absence from the service of the registered manager. This included support from a manager in a service within the provider group, additional support visits from the operations manager, the provider and the deputy manager working office hours.

The registered manager told us there was a programme of audit in place and this included mattress audits, checks on the building and health and safety checks. We saw these were carried out at the intervals identified by the provider's policy and overall in relation to mattress audits, checks on the building and health and safety checks, these did show how actions were addressed. For example, mattress replacement if a mattress failed the audit.

Staff spoke highly of the registered manager and said they were approachable and supportive. One staff member however, said the manager "had a lot to learn." Some people who used the service knew who the manager was but others did not. One person told us they had never seen the manager and another said they had seen the manager but did not see her often enough. The relatives we spoke with thought the home was well managed and had confidence in the registered manager. One staff member we spoke with said the registered manager worked hard and did their best but said they would benefit from more support from the provider. They said, "[Name of provider] is here once in a blue moon."

People thought the home was well run; one person told us they thought so because "you can have what you want during the day, tea and biscuits." We spoke with another person who told us the home was well managed because "it is nice and clean." A third person told us, "The people are nice and friendly." They said this made them feel the service was well managed.

People who used the service and their relatives were asked for their views about the care and support the service offered. A satisfaction survey was carried out in September 2016. We looked at the results of this and saw there was overall a high degree of satisfaction with the service. However, we saw a relative had commented on the difficulties their family member had due to being hard of hearing which affected their ability to participate in activities. There was no evidence of any action taken in response to this. There were also several comments made about people's clothing going missing in the home or family members wearing other people's clothing. The registered manager said they gave feedback on the results of the survey by producing a poster 'Have your say' which was placed on a noticeboard in the home to show the action taken to improve the service. Issues regarding clothing were' reported to the laundry'. There was no information on how the service was going to ensure improvements in this area and prevent any re-occurrence of the problem.

We concluded the provider still did not have systems that were effective to assess, monitor and improve the quality and safety of services. This is a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

Staff meetings were not held on a regular basis. The registered manager said they could not rota staff and pay them for attendance at staff meetings so they were infrequent and poorly attended. They said they

relied on a more individual approach such as supervision meetings and memo's. We were shown records of a night nurses meeting that took place in January 2016, a nurse's meeting in March 2016 and a senior's meeting in March 2016. After the inspection, the registered manager provided us with copies of the records of a staff and nurse's meeting in June 2016, and a staff meeting in October 2016. The meeting in October 2016 was attended by the registered manager, two senior staff and a nurse. No care workers were listed in the attendance record of the meeting. Staff said overall they were informed of important issues that affected the service, but said they did not have chance to get together to discuss the service as a group, for example, where improvements were needed. One staff member said, "I'm not sure of internal things going on such as safeguarding."

Records showed the registered manager had systems in place to monitor accidents and incidents to minimise the risk of re-occurrence.