AAA Medics Ltd

Leylands Rest Home

Inspection report

16-18 Leylands Lane
Heaton
Bradford
West Yorkshire
BD9 5PX

Tel: 01274543935

Date of inspection visit:
03 February 2017
08 February 2017

Date of publication:
28 March 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place over two days on 3 and 8 February 2017 and was unannounced.

At the last inspection in January 2016 we rated the service as 'Inadequate' and in 'Special Measures'. We found breaches of regulations relating to person centred care, dignity and respect, safe care and treatment, staffing and good governance. We issued a warning notice in relation to good governance and requirement actions for the other breaches. Following the inspection we told the provider they must improve. The commissioners at the local authority were made aware of our concerns and the provider agreed to a voluntary suspension of placements.

Leylands Rest Home is registered to provide accommodation and personal care for up to 17 older people, including people living with dementia. There are nine single and four shared bedrooms, each with en-suite facilities. There are two lounges, a dining room and a bathroom on the ground floor. On the first day of the inspection there were 12 people living at the home and there were 11 people on the second day of our inspection.

The registered manager has been at the service since it's registration with the Care Quality Commission in April 2015 and was the registered manager of the home under the previous registration. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they liked the registered manager and staff.

Standards of hygiene and infection control were poor and not all of the necessary environmental safety checks had been completed.

Staff knew about different forms of abuse and knew how to report their concerns.

Risks to people were not well managed. Risk assessments lacked detail, for example, where a scoring system was used for assessing people's risk of developing pressure sores, staff did not know what the score meant. Accidents were not always recorded appropriately. Staff used unsafe and inappropriate moving and handling techniques.

We noted some improvements in management of medicines. However systems were not being followed to make sure people received their medicines in line with the prescriber's and manufacturer's instructions.

The registered manager was not able to explain or show us how staffing levels had been calculated. We were concerned there were not enough staff on duty at all times to meet the needs of people living at the

home. Recruitment processes were followed to make sure new staff were safe and suitable to work in the care sector. Staff told us they felt supported by the registered manager.

Staff were well-meaning in their approach but people's privacy and dignity were sometimes compromised. There was a lack of person centred approach and people living with dementia were not always supported to enable them to make choices. Staff training was badly organised and insufficient to support staff in their roles.

People did not receive nutritionally balanced diets. Food was of poor quality and there was little choice available. People's cultural dietary requirements were not met.

Procedures were not always followed to make sure make sure service was compliant with the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards

People were supported by community healthcare professionals. However the advice given was not always included in care plans.
Generally care plans provided staff with sufficient information about people's needs and how they preferred their care, treatment and support to be delivered. A relative we spoke with told us they were fully involved in developing their care plan and attended regular review meetings to discuss their care and treatment.

People were not provided with appropriate and person centred stimulation. People had limited access to the community as they had to pay for staff to accompany them on individual outings.
There was no information about the home available to people as neither a Statement of Purpose nor a Service user guide were available.

There was a lack of effective and strong leadership. Quality assurance systems had been put in place however these were not fully embedded or robust which is evident from the continued breaches we found at this inspection.

We found continued shortfalls in the care and service provided to people. We identified seven breaches in regulations. These related to staffing, person-centred care, dignity and respect, consent, the premises, safe care and treatment and good governance. The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service remains in 'Special measures'.
Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from

operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Safe and effective medicine systems were not always in place which meant we could not be assured people received their medicines appropriately.

There were not enough staff deployed to meet people's needs. Safe staff recruitment processes ensured new staff's suitability to work in the care service.

Effective systems were not in place to keep the premises clean and control the spread of infection.

Is the service effective?

Inadequate

The service was not effective.

Staff training was insufficient to ensure they had the skills and knowledge to meet people's needs.

The service was not meeting the legal requirements relating to The Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were not met. Food was of poor quality and choice was limited.

Is the service caring?

Inadequate

The service was not caring

People gave positive feedback about staff but people were not always treated with respect and dignity.

Staff did not always communicate with people in a person centred and appropriate manner.

There was a lack of person centred approach.

Is the service responsive?

Inadequate

The service was not always responsive.

Staff knew people well and demonstrated a good understanding of people's individual preferences. However, this information was not always translated into people's care files.

People were not provided with appropriate and person centred stimulation.

Is the service well-led?

Inadequate

The service was not well-led.

There was a registered manager in post.

There was a lack of effective auditing of the quality and safety of the service.

There was no information about the provision of service available to people.

Leylands Rest 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.

This inspection took place on 3 and 8 February 2017 and was unannounced.

The inspection was carried out over two days. On the first day there were two inspectors and on the second day two inspectors and a specialist advisor in mental capacity act and deprivation of liberty safeguards were present.

Before the inspection we reviewed the information we held about the service. This included speaking with the local authority contracts and safeguarding teams. We had asked the provider to complete a Provider Information Return (PIR) prior this inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This document had been completed and returned to us within the required timescale.

During our inspection we looked at nine people's care records, eight people's medication records and three staff files as well as records relating to the management of the service. We spoke with the Registered manager, five members of staff, the cook and the registered provider.

Inadequate

Is the service safe?

Our findings

At our previous inspection in January 2016 we found breaches of regulation in relation to environmental safety and infection control.

On the first day of this inspection we saw poor standards of cleanliness throughout the home. On arrival at the service we saw both downstairs toilets were dirty with faecal smearing. We saw people had used plastic bags as there was no toilet paper available in one of the toilets and had put the soiled bags in the bin. We also saw there were no paper towels available. Although we pointed this out to staff immediately, the situation remained unchanged when we checked again over three hours later.

In the bathroom cupboard we saw boxes of dressings mixed with various items including hair rollers, toiletries and dirty clogged razors.

In one person's bedroom there was a very strong and unpleasant odour. We found urine and faeces in the wastepaper bin. In another room there was a strong odour of urine and we saw faecal smearing on an unused bed base in the room. In another person's room we found the denture pot was encrusted with food debris with slimy water in the bottom of the pot.

Surfaces throughout the home were dusty. The four easy chairs in the dining room were stained yellow.

We saw people were given drinks in stained and dirty cups and we found dirty and stained cutlery in use.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw a number of unsafe and inappropriate moving and handling techniques during our inspection. Such as people being moved backwards in wheelchairs without footplates and being lifted underneath their arms both of which are unsafe practices. We saw people's feet were knocked into furniture as they were pulled backwards in wheelchairs.

Risk assessments were in place where areas of potential risk to people's general health and welfare had been identified. These included assessments relating to people's mobility, nutrition and skin care. However, where assessments were completed it was not always clear what the level of risk meant for people. For example, the 'Maelor Scale' was used to assess the risk of pressure sores. We saw one person had scored 8 in their assessment. There was information about how to complete the assessment, however there was no information about what a score of 8 meant for this person such as the level of risk of them developing a pressure sore. We asked two care staff what a score of 8 meant and whether this person was at risk of developing a pressure sore. Neither were able to tell us or show us information about this.

Appropriate detail was not always being recorded in relation to accidents and incidents. For example, within one person's care plan review for January 2017 the following statement was recorded, 'District Nurse visited

21 January for 2 skin tears on R leg and visited 26 January to change dressing on R leg.' There was no information or record within this person's care file to show how these injuries may have been sustained. We asked a member of care staff about the injury and they told us, "I am not sure how it happened, but I think it was on their bed at night." We asked the registered manager about the injury and they said, "I am not sure but there should be an incident form about it." We checked the incident forms, body maps and falls diaries for this person and could not see any other record of these skin tears or information relating to how the skin tears may have been sustained. We also saw a body map completed for this person on 17 November 2016 which stated 'Cut to back of head bleeding to head.' We could also find no record or details of how this injury had been sustained or additional monitoring which was in place with this being a potential head injury.

The same person was assessed as being at 'very high risk' of falls. An entry within their falls diary showed they had a fall on 27 November 2016 at 3pm where they 'missed the chair.' The next entry recorded was an incident at 4.10pm on 27 January 2017 which stated; 'Slip off chair landed on bottom no injuries.' As both incidents occurred at similar times and involved a chair we wanted to check what actions had been taken to reduce risk. We checked the incident forms and daily notes for both accidents and found limited information. For example, from the information recorded regarding the January accident we were unable to establish whether the person had slipped off the chair whilst trying to move as in the previous incident in November. We could also find no details of what action had been taken to reduce the risk of such an incident occurring again. The person's falls risk assessment had not been reviewed and updated following their two most recent falls. We also saw the person's needs had changed over the past month but their moving and handling risk assessment had not been updated to reflect this change.

We saw two stairlifts were in use at the home. We asked the registered manager for risk assessments associated with use of the stairlifts. They told us they only had a risk assessment for people over a certain weight using the stairlift. This was not applicable to any of the people living at the home. The stairlifts were subject to regular maintenance checks. We saw evidence that the gas and electricity systems had been checked and were safe. However Legionella testing to make sure the water supply was safe had not been tested for over three years.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in January 2016 we found breaches of regulation in relation to medicines management. On this inspection we saw some improvements had been made, for example protocols had been put in place for PRN (as required) medicines and regular checks on medicine stocks had been completed. We found the stock balances we checked were correct.

However, we found medicines were not always given in line with the prescriber's instructions. For example, we asked the senior care assistant administering morning tablets if anybody was prescribed medicines need to be taken thirty to sixty minutes before food. They told us there were and gave us names of three people. We asked if these received their medicines before breakfast. The senior care assistant said they did not. Following this conversation the senior care assistant went to give one of these people their tablets. We asked the senior care assistant if this person had already eaten their breakfast. They said they had because night staff had given them their breakfast. We knew this to be incorrect as we had observed day staff serving breakfast to the people named by the senior care assistant. We told the care assistant this and they said they would not give it but would leave a gap on the person's Medication Administration Record (MAR) because they couldn't say they had refused the tablet. They asked us if this was acceptable. We told them they needed to work in line with their medication policy and procedures.

We saw the senior care assistant trying to administer medicine to a person who was saying they needed the toilet. The senior care assistant ignored this and continued to insist the person took their medicines. This resulted in the person refusing their medicines as they kept saying they needed the toilet.

We saw from one person's MAR that no record of administration had been made for one of their medicines. The senior care assistant told us they would have had it as it was included in their dosette and they had given all of those but they had not looked at the MAR with that particular tablet on it. The senior care assistant asked the person if they had applied their prescribed creams that morning. The person said, "No I can't do it myself." The senior care assistant then took the person to the bathroom to apply their face cream. We also noted the MAR had been completed to indicate the person had refused other prescribed creams. We asked when these had been refused and the senior care assistant told us it was whilst they had been applying their face cream. However the recording code for refused had been made on the MAR prior to the person going to the bathroom.

We looked at the MAR for another person after they had been given their medicines. We noticed their antibiotic had not been signed as given. We asked the senior care assistant why that was. They said they did not know the person was on antibiotics. This meant they had not looked at all of the person's MAR charts. The MAR for this antibiotic had been poorly completed. There was no date to say when it had been received and the days numbered on the MAR suggested it had been administered the day after our inspection.

We saw one person was prescribed a cream on a PRN (as required) basis. A note on the MAR said 'None in stock re-order when required.' This meant the cream would not be immediately available to the person when they needed it.

We saw temperature checks of medicine storage were to be recorded daily. There were some gaps but generally the temperatures had been taken and were under the recommended 26°C. However on the day of our inspection the thermometer in the medicine cabinet read 30°C.

This meant systems were not being followed to make sure people received their medicines in line with the prescriber's and manufacturer's instructions.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us sufficient care staff were employed for operational purposes although they did not use a recognised staffing tool to determine staffing levels.

The registered manager told us at the time of inspection seven people required two staff members to assist them with their personal care needs and agency staff had covered some shifts on night duty. Bedrooms were arranged over three floors and care records indicated that some people were up during the night. The registered manager told us that one person with a room on the third floor was often up at night. This meant whilst night staff were attending to people who needed two staff, there were no staff available to meet the needs of people on the other two floors of the home.

The registered manager told us in addition to care staff they also employed part time domestic and catering staff. The cook worked between the hours of 9.15 am and 11.45am seven days a week. Our findings in the 'Effective domain' of this report clearly show that at the time of the inspection the catering hours at the home were insufficient to provide people with a nutritious and balanced diet and a positive dining experience.

Care staff told us they felt there was sufficient staff on duty to meet people's needs and staff worked well together as a team. However, they told us in addition to their normal duties they were responsible for washing up after mealtimes in the kitchen situated on the lower ground floor, for preparing the evening meal and for managing the laundry. The care staff also told us that no domestic staff worked at the weekend and therefore they were also responsible for ensuring the home was kept clean and tidy.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw safe recruitment procedures were followed for staff working at the home. We noted DBS (Disclosure and Barring Service) checks were taken for students undertaking work experience at the service.
Staff we spoke with understood about what constituted abuse and told us they had received training in this area. The registered manager told us senior staff knew when and how to make safeguarding alerts and staff confirmed this with us.

Inadequate

Is the service effective?

Our findings

At our last inspection in January 2016 we found a breach of regulation in relation to staff training.

On this inspection we saw a number of instances where staff would have benefitted from additional training. For example, we saw staff applying a number of inappropriate and unsafe moving and handling techniques during our inspection.

We saw from the training matrix that staff had been recorded as having received training in a number of areas relevant to their role. However the training matrix showed that seven subjects including equality and diversity, dignity in care, safeguarding, deprivation of liberty and fire safety had all been delivered on one day. On another day, records showed staff had received training in eight subjects including moving and handling, mental capacity, infection control and health and safety. The training matrix indicated that all care staff employed at the home, including night staff and the registered manager, had taken this training on the same days. The registered manager told us the training had been delivered by an outside training company and had taken place in one of the lounges in the home. We asked the registered manager who had been responsible for the care of the people living at the home whilst this training had been going on. They told us staff had done it at the same time as undergoing training. They also told us, when asked, that staff who had worked the previous night had undertaken the training.

This was not a suitable arrangement for effective training. Covering a large number of subject areas in one day meant the training could not be robust particularly when, at the same time as undertaking training, staff were going about their usual care duties.
Staff received regular supervision and annual appraisal with the registered manager.

On the first day of our inspection a college trainee was working in the home. The registered manager told us this person would not be left alone with people who lived at the home. However, we saw periods of up to 45 minutes when the trainee was left by themselves with people who lived at the home. We saw some of their practices were inappropriate. For example, we observed two occasions when they tried to get people's attention by clicking in the person's face. As no staff were in attendance this poor practice would not have been witnessed and therefore not identified as a training need.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff had completed recent 'React to Red' training. This is training aimed at care staff for the prevention of pressure sores. However, there was little evidence this training had been put into practice, particularly with regard to the importance of good nutrition in promoting healthy skin.

We looked at the care plans and saw people had been seen by GPs, district nurses and specialist nurses. The registered manager explained they had arranged for an optician to visit the home in March 2017 to offer people an eye test.

We saw the advice of healthcare professionals was not always translated into person centred care plans. For example, one person was assessed as at 'very high risk' of falls and had been referred to the district nurses for a falls assessment. We saw an entry in the health professionals log to say this person had received a falls assessment. However there was no information to show what the outcome and recommendations from the district nurse were. We asked care staff and the registered manager about this and they were unable to tell us or show where this information was recorded within this person's care records.

We saw staff had arranged a telephone consultation with one person's GP on the day of our visit because they had noticed that this person was unwell. We saw staff arranged to collect a prescription of antibiotics for them.

One person who used the service told us, "The food leaves a lot to be desired but it's edible. I would like more choice and bigger portions." Another person told us, "The food is alright. I would prefer my lunch a bit later but I am used to the routine here now." A relative told us, "I think the food is ok. The portions could be bigger. Sometimes they only get a sandwich or something light for tea. They could probably have something extra if they asked but [my relative] is not the kind of person who would ask."

We looked at the menus in use and saw these had been developed in March 2015. There were no alternative meal options available on the menu. The cook told us if people did not like what was on the menu they could prepare something different such as an omelette or beans on toast. The registered manager and registered provider told us they regularly consulted people about any changes or specific requests on the menu during residents meetings. We did not see reference to this in the minutes of meetings we looked at.

Staff told us people were always offered choices of foods. However, we saw this was not always the case. On the first day of our inspection staff told us they had asked everyone what they wanted for lunch in the morning. However, both inspectors were sat in two different communal areas from 8am until lunchtime and did not observe anyone being asked for their meal preferences.

A menu on the blackboard in the dining room stated there was a choice of cereals, toast, scrambled egg and tomatoes for breakfast. Care staff told us no one wanted a cooked breakfast on the day of our inspection. However, we did not observe people being offered the cooked breakfast option. One person told us they sometimes had a cooked breakfast but did not fancy one today as they were going out for lunch.

We saw at least four people had toast for breakfast. Each person was given one slice of lightly toasted bread with a small amount of butter. No-one was asked how many slices of toast they would like or offered conserves such as jam and marmalade despite this being available in the kitchen. We asked one person if they were enjoying their toast. They told us, "The bread is too thick. I preferred it when they had thinner bread, it was more crispy. I have forgotten what marmalade looks like. I have my toast like this because this is how it comes."

We found mealtime experiences lacked attention to detail and a person centred approach.

At lunchtime on the first day of our inspection we saw the meal had been placed in the hot serving trolley at 10.45am. On the second day, we saw the lunchtime meal was already in the hot trolley when we arrived at 10.30am. The food remained in the trolley until it was served to people up to two hours later. The care staff confirmed they probed and recorded the temperature of the food before it was served. However, it was apparent when discussing the matter with the registered manager that the reason food was left so long in the hot cabinet was because the cook only worked two hours a day and finished work before lunch was served.

On the first day everyone, except three people who had a soft diet, had breaded fish, chips and mushy peas. No one was offered salt, pepper or vinegar to accompany their meal. Some people were offered ketchup. We found the portions were small and second helpings were not consistently offered. For example, we saw two people were given a small piece of fish, mushy peas and five chips. Both people ate all of the food on their plate but were not offered second helpings. We did not see any recorded reasons why these people were given a small meal.

On the second day, the menu described the lunchtime meal as roast turkey and roasted potatoes. However we saw the meal consisted of sandwich ham warmed in gravy, carrots and fried potatoes. The desert was bread and butter pudding which we saw was very burnt with the sultanas on top of the pudding completely black. We asked for this not to be served but the registered manager asked the care staff to remove the burned top and serve it. We had to ask again for the pudding not to be served as it was not fit to be eaten.

Where people required support to eat their lunch we saw staff did not dedicate their time to supporting people. Staff stood over people and performed other tasks at the same time which showed a lack of respect for the person. Staff did not engage with the people they were supporting to explain what the different components of the meal were and in one case we saw a staff member blow on a spoonful of food before putting it to the person's mouth. We also saw examples where people would have benefitted from prompting to eat their meal. For example, we saw one person ate their mushy peas with their fingers. Staff told us this person sometimes preferred to use a spoon to eat their meal but they had been provided with a knife and fork.

We spoke with the cook who told us they worked 9.15am to 11.45am during the week and another cook worked the same hours at weekends. This meant care staff prepared and served breakfast and the evening meal. We found the quality, quantity and nutritional value of food to be poor.

On the first day of the inspection the cook showed us they were preparing macaroni cheese and vegetable soup for tea. They said they would leave this food to cool so care staff could reheat it when required later that evening. We asked the cook how they had prepared the vegetable soup. They showed us they had boiled a pan of water and mixed in several sachets of value brand vegetable cup a soup. They did not add anything extra to add flavour, calories or nutritional value.

We saw chocolate éclairs were on the menu for pudding at tea time. We saw a box of six chocolate éclairs defrosting in the fridge. This meant there were not enough for all 12 people who lived at the home. The cook told us staff had asked people whether they wanted a chocolate éclair the day before so they knew how many to get out of the freezer. They showed us there were yogurts for people who did not want a chocolate éclair. However, this approach was not appropriate for people who lived with dementia and did not provide scope for people to change their mind. On the second day we saw 12 small crumpets had been defrosted which meant only one for each person along with soup.

Food items such as the cereals, jam, marmalade, soup and yogurts were supermarket value range products. The registered provider told us they did the weekly shop and purchased these products "due to cost." We saw no evidence that people had been given a choice about whether they would prefer an alternative brand for these products.

We were concerned that the food provided did not ensure people received a varied and balanced diet. We were told by staff that people were offered fresh fruit on a regular basis. On the first day of our inspection we asked the cook to show us where they kept the fresh fruit. We saw nine apples and four bananas. This meant there was only enough for each person to have one piece of fresh fruit. There were tinned fruit and frozen

vegetables available. However, we did not see people being offered or provided with these during our inspection. On the second day, we found four apples and one banana. The cook said the planned desert of fruit pudding could not be made as there was not enough fruit available.

We found people's individual dietary needs and preferences were not appropriately catered for. We were told by staff and the registered manager that several people had their weights monitored because they were at risk of losing weight. The cook had no knowledge of how to ensure food was appropriately fortified to ensure people consumed maximum calories. For example, on the first day of our inspection there was no cream available to add to the food of people who were at risk of losing weight.

The cook told us three people required a soft diet. During lunchtime we saw these people received blended fish in sauce, mashed potato and blended carrot. We saw the food was blended and served separately so that people could taste the individual components of their meal. We asked the cook how they made the mashed potato. They showed us a plastic box labelled 'mash' which had powdered potato in it. They told us they mixed this with water but did not add any butter or cream. On the second day of our inspection we observed staff pouring cold cream over people's warm meals. When we asked why the cream was not added during preparation the staff member said 'it's the way we have been told to do it.'

The cook told us two people were diabetic but they were not sure who these people were. They told us this meant these people did not have puddings and would be offered fresh fruit instead. We asked if they made or ordered separate low sugar alternatives for people who were diabetic. They said they sometimes made low sugar alternatives but did not have any ingredients to do so at the moment.

We saw people were served biscuits and drinks between meals. Although cake was on the menu we did not see any cake offered.

We saw people's fluid intake was recorded. Of the eleven records we saw only two indicated the person had received a drink after 8pm until the next morning. Apart from one person who was able to make their own warm drinks, everybody was recorded as having water for their suppertime drink. We saw every drink on all of the charts we looked at was recorded as 200mls. However on both days of inspection we saw people served drinks in different sized cups and on several occasions we saw they did not drink the full cupful. The amounts of fluid taken had not been added up to see if people had received enough fluids and there were no fluid intake targets recorded. The practice of recording everybody's fluid intake had been reviewed by the second day of our inspection but the recording had not improved.

We saw one person had their food intake recorded to ensure their intake was sufficient to their needs. We found staff were not always recording what the person had to eat. For example, records showed the person was not being offered anything to eat between their evening meal at 5pm and breakfast the following day. This was discussed with the senior care assistant who confirmed the person had a light supper and snacks but acknowledged staff had failed to record this. It was apparent that although staff were not completing the documentation correctly this had not been checked by senior staff or identified through the internal audits systems in place.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We asked one care assistant if they knew about the authorised DOLs for one person. They told us, "It's when people come and write things down about people." Another staff member told us the authorised DOLs meant, "If [person's name] wants to go to bed. They can go to bed." This meant both staff were unable to demonstrate an understanding of what the authorised DOLs meant for this person or how it impacted upon their day to day work.

Where capacity assessments were in place we saw these were not always comprehensively completed. For example, for one person who had been assessed as not having capacity we saw the sections 'Actions to support personal decision making' and ' Actions to be taken after the service user lacks decision making capacity' were not completed. This risked that staff would not have the information they needed to ensure they provided appropriate support with decision making.

We saw eight people had a DoLS authorisation in place. We inspected three granted authorisations where the supervisory body had attached conditions. Whilst conditions were being met this was not with the rigor required. For example, one condition required the managing authority to devise care plans with the involvement of family members to provide access to outdoor activities. Our observations and discussion with the registered manager established there had been some access into the community with family, but no care plan existed nor any recognition of the person's more recent declining health which prevented the condition being met.

We saw two people shared a room. Our discussion with the registered manager established both people had a DoLS in place and as such were without capacity to make their own decisions. We asked what process had been followed to ensure the decision for these two people to share a room had been in their best interests. Whilst the registered manager was able to demonstrate a considerable understanding of the people, we saw no written evidence of a best interest meeting where family and staff with knowledge of both people had taken place.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw where issues around lasting powers of attorney required consideration in care planning this was clearly annotated in the care file and supported with a copy of the Court of Protection's decision. Care plans showed the provider was, in this case, ensuring inclusive consent procedures were being enacted in determining people's care needs.

We spoke also about the use of bed-rails. Answers we received demonstrated when people had capacity they were consulted on the use of bed-rails and understood the action was proportionate to the potential harm. Where there was a lack of capacity or the person's capacity fluctuated, family members were consulted before bed-rails were used. We spoke with one service user who had capacity and the care record suggested they had requested bed-rails. The person said "Oh yes I need the rails, I would be anxious if they were not there".

Inadequate

Is the service caring?

Our findings

People who lived at the home and the relatives we spoke with provided positive feedback about care staff. One person told us, "Staff are lovely, they do a good job, you can have a laugh with them. I have a real friendship with staff." A relative told us, "Everything seems fine, staff do a good job in a difficult situation." Another relative said, "I have no concerns, staff do their very best. [Person's name] is always clean and tidy whenever I visit them."

Despite this positive feedback about staff and our observations of some positive and kind interactions, we observed a number of examples where people were not treated with respect and dignity. This included people with food stains on their faces and clothing, people wearing dirty shoes and people with dirty fingernails. We saw one occasion where staff encouraged a person to change their top because they had spilt food on it but there were many other occasions where this was not the case.

During breakfast we saw one person eating jam sandwiches with their hands. The person had a brown crusted substance on their fingers and underneath their finger nails. From the smell and appearance we judged this substance to be faeces. We asked a member of care staff to clean this person's hands. The staff member did so at the dining table in front of other people. Staff did not replace the sandwiches the person had been eating with fresh ones and there was still visible dirt underneath the person's finger nails.

The tablecloth on one table at breakfast had a large rip in the centre of it and one of the clothes protector provided to one person had several holes in it. We saw two occasions where one person asked for a tissue to blow their nose. On both occasions staff brought blue roll kitchen paper to wipe their nose with.

We saw one person being supported by staff to mobilise had their clothes in a state of disarray which meant their incontinence pad was on display. Staff did not intervene to protect this person's dignity.

We saw bathing records which indicated people had been bathed in water with temperatures as low as 33°C. This would not provide a pleasant or enjoyable bathing experience and demonstrated a lack of regard for people's comfort.

The registered manager told us that weighing people was done as an activity with people weighed in communal areas. This demonstrated a lack of regard for people's privacy and dignity.

We saw on a handover sheet staff had recorded there was an unpleasant odour in one of the bedrooms and suggested there could be a dead mouse in the room. The person who used the service was in the room at the time the report was made. We found the odour to be from the waste paper bin in the room which contained urine and faeces. However, staff had not taken action to establish or eliminate the cause of the unpleasant odour even though the person was in the room.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people told us they liked being able to make their own hot drinks and did so in the kitchen area in the dining room. However, where people were living with more advanced dementia we saw they were not always given opportunities to help retain their independence. For example, we raised the issue of there being no condiments such as salt and pepper on the dining room tables for people to help themselves to during mealtimes. The registered provider told us they had done this in the past but one person had thrown them on the floor so they were removed.

We were concerned people living with dementia did not always have a voice. Staff did not always communicate with people in a person centred and appropriate manner. For example, during breakfast we saw a staff member was struggling to understand what drink a person wanted. The staff member brought a picture book and the person pointed to the picture of a cup of tea which was promptly provided. However, this was the only occasion we saw this book used. We observed several other examples where staff were unable to understand what this person and others living with dementia were telling them.

We also saw staff did not always offer and explain choices to people in an appropriate way. For example, at lunchtime people were verbally offered a choice of orange or apple juice or water with their meal. However, people living with dementia would have benefitted from being shown the options so they could make an informed choice. When we raised that people were not consistently offered options and choices with the registered provider they told us, "But how many of my residents can give you an answer?" This showed a lack of respect and understanding for the needs of people living with dementia.

Staff did not always give people explanations so they could understand what was happening. For example, during lunch one person had finished their meal and asked to go to the lounge. We saw staff moved the table to enable this person to move. However no explanation or warning was provided to the other person who was sat at the same table eating their pudding. This showed a lack of respect by interrupting the other person's meal and their facial expressions and verbal response also showed they had been startled and confused by the sudden movement of the table.

We saw people's religious and cultural preferences were not always met and respected. On the first day of our inspection the cook told us one person received a particular diet and they had separate storage and preparation zones to ensure this person's food was sourced, stored and prepared in line with their religious customs. On the first day of our inspection we found this food was not being stored in line with their specific religious beliefs. We showed this to the registered manager who said staff knew the arrangements for the storage of this food but had not adhered to them. When we returned on the second day of our inspection we found the food was again stored in a manner which did not meet the person's religious custom.

On our arrival on the first day of our inspection at 8am we observed two people sat in the TV lounge. A children's cartoon was on the television. We asked a member of staff if this programme was appropriate for the needs of the two people sat in this lounge. The staff member told us this programme was on because someone else in the home enjoyed watching it. This person was in bed at the time of our arrival. We were later told they usually preferred to spend their time in the dining room. This shows us the specific needs of the people sat in the lounge had not been considered.

We saw a 'bath list' was in place which said what day and what time people should receive a bath. The list went on room numbers rather than people. For example where a room had become vacant, the name of the previous occupant had been crossed out and the new occupant's name put in. This meant the new occupant would receive their bath at the same time and day as the previous person. Whilst the registered manager told us people could have additional baths to the ones on the list, the existence of the list demonstrated a lack of person centred approach.

The communal living accommodation consisted of two lounges and a dining room. The dining room provided access to stairs to the kitchen, staff toilet, laundry and manager's office and was also the only access to toilets from the front lounge, the back lounge and a bedroom. Medicines and care records were stored in this room and staff prepared drinks and washed up in a sink in the corner. A small television was situated high on the wall. As well as dining tables there were also four easy chairs. We saw wheelchair access was very difficult in this room and saw people with reduced mobility bumping into chairs and tables. Some people who used the service spent their entire day in this room. Staff told us this was their preference but we did not see people given choices or encouraged to mobilise to other rooms. The registered manager told us people liked to be in this room because this was where the staff were. We considered this arrangement to be for the benefit of staff rather than people who lived at the home.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw staff had received training in end of life care and saw 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) forms were completed appropriately in discussion with people who used the service and/or their relatives and signed by relevant professionals.

Inadequate

Is the service responsive?

Our findings

We saw staff knew people well and demonstrated a good understanding of people's individual preferences. However, this information was not always translated into people's care files and we saw staff did not always support people in line with their preferences. .

For example, we saw one person was provided with very milky and weak tea. We asked staff about this and they told us this person would only drink tea if it was made this way. This information was not detailed in this person's care file. The person was at high risk of developing infections and should have been encouraged to drink additional fluids; therefore this information was important to ensure staff could encourage this person to drink.

Generally care plans provided staff with sufficient information about people's needs and how they preferred their care, treatment and support to be delivered. However, the files we looked at were not particularly user friendly as they were bulky and information was at times difficult to find.

People's care records also contained a 'How I would like to be cared for' document. Similar documents are widely used in other areas of the health and social care sector. They provide staff with a life history about the person, their family and occupation among other areas. They also list people's likes and dislikes and how they prefer to receive their care. We spoke with the relative of one person who used the service and they told us they were fully involved in developing their care plan and attended regular review meetings to discuss their care and treatment. The records we looked at evidenced this.

We saw people were not provided with appropriate and person centred stimulation.

We saw examples where staff did not ensure the television programmes on offer were appropriate to people's needs and preferences. One person told us they really enjoyed country music. They had brought a CD of one of their favourite artists to play in the dining room. Staff played this CD for them and we saw this person really enjoyed singing along to the music. However, staff had left the television on in the corner of the room. On the second day of our inspection we saw the television in the dining room playing an American programme which nobody was paying attention to. A CD was playing music in the same room. This situation can be confusing for people living with dementia and prevents people being able to concentrate and enjoy either activity.

The blackboard in the dining room detailed the morning activities were menu planning, exercises and noughts and crosses and the afternoon activities were colouring, film on TV and socialising. We did not see any of the planned morning activities taking place. We asked care staff about this. They told us the information on the blackboard was only used as a rough guide.

On the morning of the first day of our inspection we saw one person looking at a word search book with the support of the college trainee. During the afternoon we observed a staff member sat next to two people in the dining room. The staff member was colouring but not engaging with either of the people sat beside

them. We asked the staff member about this and they said they had been colouring with another person who was sat in the lounge. We spoke with this person and they showed us some pictures they had coloured and said they had enjoyed this. The staff member said the two people sat in the dining room did not usually enjoy colouring. Despite this, the staff member continued colouring and did not try and engage the people sat beside them in activities which they may have preferred.

Care staff showed us the box of equipment they used for activities. We saw this included skittles, puzzle books and several jigsaws. We saw all of the pieces for the different jigsaws were mixed up at the bottom of the box so it was difficult to see which pieces were required for each jigsaw. We saw an album of pictures of people. Staff told us they used this for reminiscence as they were pictures of people who had previously lived at the home. Some of these pictures were taken in 1988 so we asked staff if they knew these people, they were unable to remember any of the people in the pictures but said they must have lived at the home at "some point". We were concerned that looking at photographs of people who were not familiar to them may have been confusing for people living with dementia.

On the second day of our inspection the registered manager told us this was a 'rummage' rather than an activities box. A rummage box should contain items which would be recognisable to people that they can engage with. As well as the items listed above, we saw the box contained a games consul with its electrical fittings in a tangled state and some torn pages of magazines. We did not consider these items to be suitable for an effective rummage box.

We saw a notice on the wall of the lounge with details of 'upcoming events'. This showed a singer had attended in November 2016, a choir in December 2016 and music for health in January 2017. There was no information about what entertainment was scheduled for the coming months.

We saw no evidence of there being any planned or recent trips out. The registered manager told us there had been a trip in September 2016 but they couldn't provide us with details of where this had been to or who had attended. One care worker told us they remembered visiting 'A museum in Bradford about a year ago.'

The registered manager told us they were not able to take people who lived at the home out individually as people could not afford it. They explained to us that if staff accompanied people out, the person was charged with the staff's hourly pay rate for the time they were out. The registered manager said that people who needed two staff to meet their needs would have to pay two staffs hourly rate. We asked for evidence to show that people had been informed of this and were told there was none.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw evidence of one complaint received by the service. This complaint had been received several months prior to the inspection. Although a response had been made to the complainant initially, there was little evidence of continued efforts to resolve the issue and the complaint remained unresolved.

Inadequate

Is the service well-led?

Our findings

The home had a registered manager who was present on both days of the inspection, as was the provider.

People's feedback about the registered manager was positive. One person told us, "They are lovely; I can go to her with anything."

At our last inspection in January 2016 we found breaches of regulation in relation to governance of the service. We issued a warning notice to the provider and registered manager.

On this inspection we saw some environmental improvements had been made and saw some new documentation had been introduced. However, we identified a number of issues which demonstrated the service had failed to make necessary improvements.

We were concerned that some issues we brought to the attention of the registered manager and registered provider were not appropriately addressed on the first day of our inspection. For example, the storage of foods in accordance with people's cultural needs. This showed a failure to respond to the issues we raised with them.

On the second day of our inspection the provider challenged some of our feedback given at the end of our first day of inspection. This was in relation to music and television playing at the same time in the dining room. The provider told us staff had said this had not happened. However we had found the same issue on the second day of inspection. This had not been recognised by the registered manager.

We were also concerned that the provider had failed to take action in relation to recent concerns raised by the local authority about the stairlifts in use at the service. Although no directive was issued by either the local authority of by the fire officer, suggestions were made to improve safety. When we asked to see the risk assessment produced as a result of these concerns the registered manager told us they had not completed one. An audit of the whole building conducted after concerns had been raised did not include any reference to the stairlifts.

The registered manager had conducted a range of audits but we found these were limited in their scope and did not result in overall improvements. Examples of this included an 'Audits log' for fluid charts had not identified that daily intake was not being totalled or that fluids were not being recorded after 8pm and the outcome for an audit of bedrooms said 'All faults given to provider.' The outcome for the care plan audit said 'Added any necessary information' but did not say which care plans had been audited or what information was missing.

Following our last inspection the provider had told us in their action plan that issues around staff training had been addressed. However, auditing of training had failed to identify the poor quality and poor organisation of training.

The registered manager told us they audited accidents in home. However, we saw this consisted only of how the accident had been managed in relation to the individual concerned. This meant no analysis was taking place to see if any additional measures could be put in place to reduce the number of accidents.

There was no overall auditing of people's weights to establish any patterns of change in people's weights.

The poor quality of food and lack of availability of ingredients to make sure people received appropriate diet and nutrition had not been recognised and identified. Menus were not checked against the meals provided.

Practices observed by or known to the registered manager which put people at risk or compromised people's privacy and dignity had not been recognised as unsafe or inappropriate. Examples of this included lifting people under their arms, pulling people backwards in wheelchairs, use of bath lists and weighing people in public areas.

There was no tool in use to determine staffing levels in relation to people's dependencies and the layout of the building.

We saw evidence the provider had undertaken audits of the environment. These were recorded in a note book but there was no evidence of how issues identified were related to the registered manager.

When we asked to see the Statement of purpose and Service user guide, the registered manager told us neither were available. When we asked how people had been made of aware they would have to pay staff's hourly rate for individual outings the registered manager said they had not been informed.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw a notice in the TV room which advertised service user and relative meetings scheduled for February, May, July and October 2017 and stated 'all are welcome.' Minutes from previous meetings were available. The service does not have a website but the rating given at the previous inspection was displayed in the hallway.

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 9 HSCA RA Regulations 2014 Person-centred care Care was not always delivered with a person centred approach. Regulation 9 (1)

The enforcement action we took:

Notice of proposal to cancel registration,

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with respect and dignity needs were not always considered and met. Regulation 10 (1)

The enforcement action we took:

Notice of proposal to cancel registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment of service users was not sought in accordance with the Mental Capacity Act 2005. Regulation 11(1)

The enforcement action we took:

Notice of proposal to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always managed safely. Regulation 12 (2)(g) People living at the home were not always protected by safe systems make sure the premises were safe and infection control measures adequately followed. Regulation 12 (2)d and h)

	Risks to the health and safety of service users were not appropriately assessed. Regulation 12 (2)(a)

The enforcement action we took:

Notice of proposal to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People did not receive nutritious diets suitable to their needs and cultural background. Regulation 14 (4)(a) and (c)

The enforcement action we took:

Notice of proposal to cancel registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of staff were not available to meet people's needs. Regulation 18 (1) Staff did not receive training appropriate to their role. Regulation 18 (2)(a)

The enforcement action we took:

Notice of proposal to cancel registration.