Priory Elderly Care Limited

Cooper House Care Home

Inspection report

80 Cooper Lane
Bradford
BD6 3NJ
Tel: 01274 711500
Website: www.priorygroup.com

Date of inspection visit: 16 & 17 March 2015
Date of publication: 22/05/2015

Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

We inspected Cooper House Care Home on 16 and 17 March 2015 and the visits were unannounced.

Our last inspection took place on 19 August 2014. At that time, we found breaches of legal requirements in two areas, cleanliness and infection control and assessing and monitoring the quality of the service. We asked the provider to make improvements and they told us they would be fully compliant with the regulations by 30 October 2014.

Cooper House is a purpose built care home situated in a residential area of Bradford. The home offers care to older people requiring general and specialist dementia nursing care. Cooper House provides accommodation in 80 single en-suite bedrooms with shower facilities arranged over three floors.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

The service was not well-led as the registered manager was not responding to complaints and some staff were frightened to speak with us because they thought they would get into trouble or lose their jobs. Although there were lots of audits in place these were not effective as they did not identify the areas we have found that are in breach of the regulations.

On the second day of our inspection the operations director took immediate action to strengthen the management of the home.

Staff were not being recruited safely and there were not enough staff on duty to provide the care and support people needed. We saw some staff were very good and talked with people and were confident in their role. However, some staff lacked the skills and experience to care for people in a respectful and dignified way.

We found staff were doing most of their training on the computer and were not getting supervision to help with their personal and professional development. This meant there were no formal checks on individual staff member's practice.

The medication system was not being managed safely and there was a risk of people not receiving their medication.

The home was clean and tidy and most of the bedrooms we saw had been personalised to suit the taste of the occupant.

Meals at the home were good, offering choice and variety. However, staff were not always offering people choices at mealtimes.

There was a good activities programme in place and we saw people enjoying the activities that were on offer. People also told us there were trips out which they really enjoyed.

We found the service was meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS).

We found some breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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.

Staff were not being recruited safely and there were not always enough staff on duty to deliver care and support to people.

The medication system was not well managed and there was a risk people were not receiving their medication as prescribed.

Staff understood they needed to report any suspicions of abuse, but did not know which outside agencies they could contact if they needed to.

Is the service effective?

Requires improvement

The service was not always effective.

Staff training was not up to date and staff were not receiving regular supervision or annual appraisals. This meant there was no formal support system to look at individual practice and professional development.

We found the service was meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS).

Staff were not able to deal effectively with people's behaviours that challenged the service.

People were generally positive about the food and told us there was always a choice of meal available

There were a range of health care professionals visiting the home to make sure people's health care needs were being met.

Is the service caring?

Requires improvement

The service was not always caring.

Some staff interacted well with people, however, others did not always treat people with dignity and respect.

Visitors told us they were made to feel welcome and found the on site Café Amore a nice area to sit with their relative.

Is the service responsive?

Requires improvement

The service was not always responsive, to people's needs. Care plans did not always identify people's specific needs or detail what support staff needed to offer.

There were a good range of activities and trips out on offer to keep people stimulated.

Complaints were not being recognised or dealt with effectively.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well-led.

The registered manager was not always approachable or responsive.

We identified numerous breaches of regulation which should have been identified and rectified through a programme of effective quality assurance to help continuously improve the standard of care. Although audits were completed they were not effective.

Not all of the records were up to date or accurately maintained.

Cooper House Care 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 on 16 and 17 March 2015 and was unannounced.

The inspection team consisted of two inspectors, a member of the inspectors' business support team and two experts by experience in dementia care on the first day and three inspectors on the second day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service. This included notifications from the provider and speaking with the local authority contracts and safeguarding teams. We did not ask the provider 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.

Over the two days of our inspection we spoke with 25 people who lived at Cooper House Care Home, nine relatives, three nurses, one senior care worker, 10 care workers, the chef, the handy person, two activities coordinators, one housekeeper, a visiting hairdresser, a visiting art teacher, the registered manager, area manager and operations director.

We spent time observing care in the lounge and dining room and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us. We looked around some areas of the building including bedrooms, bathrooms and communal areas. We also spent time looking at records, which included nine people's care records, five staff recruitment records and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

Recruitment procedures were in place to ensure only staff suitable to work in the caring profession were employed. These included ensuring a Disclosure and Barring Service (DBS) check and at least two written references were obtained before staff started work. Where nursing staff were employed, the service checked they were registered to practice. However, we found the recruitment procedures were not being followed.

The registered manager told us the service was supported in recruiting new staff by the organisation's Human Resource Department who ensured the recruitment procedure had been followed. They confirmed that all new members of staff were initially employed for a six month probationary period before their performance and engagement with the service was appraised and a permanent job offer made if appropriate.

However, when we looked at the recruitment files for five members of staff it was apparent that the recruitment procedure designed to ensure only people suitable to work in the caring profession were employed was not always being followed. For example, the recruitment procedure clearly stated that the interview panel should be made up of a minimum of two people and should include the potential employee's proposed line manager. However, we looked at five recruitment files and found in all cases only the registered manager had interviewed the potential employees and completed the interview records and questionnaires.

We also found for one recently employed member of staff a reference had been accepted addressed to "Whom it may concern." The letter was hand written and did not include a company stamp although it was signed and dated. The application form completed by the person did not include this referee's name or contact details and there was no evidence to show the organisation had requested the reference.

In addition, we found that there was no proof of identification on file for this person even though the recruitment policy clearly stated that new employees must provide both photographic identification and at least one document confirming their address.

This matter was discussed with the registered manager who told us they had experienced difficulty obtaining references from the person's original referees and had therefore requested a further reference. The registered manager was unable to explain why there was no proof of identity on file and acknowledged the correct recruitment and selection procedures had not been followed.

Staff disciplinary procedures were in place and we saw examples of how the disciplinary process had been followed where poor working practice had been identified. However, we saw when an allegation had been made about a member of staff the registered manager had not followed the procedure. The correct action was only taken when senior managers were contacted by a relative.

This breached Regulation 21 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our observations and discussions with people who used the service and staff showed there were not always enough staff to meet people's needs in a timely way. On the ground floor there was a nurse and four care staff on duty at 8am and a senior care assistant, who had not worked on the unit before, joined the team at 9.20am. There were 29 people on the unit and the nurse told us 14 people required the support of two staff and seven people required assistance with eating their meals.

Staff we spoke with told us they felt a nurse and four care staff was not enough to meet people's needs. One staff member said, "We don't have enough time to talk with them (people) properly as we're always rushing. I think it's important to have that time and we used to have it when I worked upstairs. I wouldn't like it if it was happening to me." Another staff member said, "No, there's not enough of us. I think we need five care staff. If we had someone to do the meals and drinks it would make such a difference." Another staff member told us, "The care staff are very good, they never stop. I think there should be five care staff but it would help if we just had someone to do the meals and drinks."

We saw staff were very busy throughout the morning and we heard call bells ringing constantly during the first two hours of the day shift. We saw there were not enough staff to respond to people and meet their requests for care and support when they needed it. For example, we heard one person in their room shouting out for staff at 9.30am. When we went in they were in bed and their clothes were on the

Is the service safe?

floor. They told us they were 'fed up' and wanted their breakfast. They said they had wanted to get up earlier and staff had said they would come back. We had seen this person stood in the doorway of their room shouting for staff when we arrived on the unit at 7.15am. Staff had gone in but the person had remained in their room. The person said they had tried to put their clothes on themselves but could not do it. We alerted staff who went in and we saw the person walking to the dining room for breakfast a short while later.

At 10.20am we saw another person in bed in their room, the curtains were drawn and they were lying on their side facing the wall. The top half of their body was dressed but they only had underwear on the lower half. They had thrown the duvet back and gestured that they wanted to get up. The sink was full of water and the person's wet flannel, top set of dentures and deodorant had been left on the bed head. There was no drink within reach. We spoke with staff who said they would be coming to the person soon as they were assisting someone else. This person was on a food and fluid chart as they were a low weight. We looked at the chart for the day and saw it was blank. The previous day's chart showed this person had last had a drink at 4.30pm. We saw this person up and dressed in the dining room at midday with a plate of marmalade sandwiches and a drink of juice which was their breakfast. Other people were sat the tables waiting for their lunch. One person said, "You get fed up of waiting."

At 11am we heard another person shouting from their room, "I can't reach it". We went in and found the person was in bed with the curtains drawn and was pointing at the light switch cord which they were trying to reach. They told us they wanted to get up. They said they had not had any breakfast and wanted another drink. We spoke with staff who went in to attend to the person. We saw this person in the dining room at midday. They said, "We're up late today, I've only just got up."

At 11.30am we saw another person in bed with the curtains drawn. They said they were waiting for staff to help them get up so they could have their breakfast. At midday staff told us they still had two people to get up, which included this person.

Night staff told us they started getting people up at 6am. We saw one lady was in bed fully clothed at 7.30am. When we asked the night staff about this they said they washed and dressed the person and then the day staff got them up. We saw this person was still in bed fully clothed two hours later.

Night staff told us they did not always have enough staff on duty and had worked alone on the top floor. We looked at the duty rotas for a four week period and saw there were six occasions when this had happened.

This breached Regulation 22 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the medicines on the nursing unit on the ground floor and the residential unit upstairs. We found there were safe arrangements in place for the ordering and disposal of medicines. We saw medicines were kept securely in locked clinical rooms and medicines requiring cold storage were refrigerated. The fridge and room temperatures were recorded daily on the nursing unit, however on the residential unit room temperatures were not recorded and there was no room thermometer. This is important as extremes of temperature can adversely affect the therapeutic properties of medicines.

We observed staff administering medicines on the nursing unit and people were given the support they needed. However, on the first day of the inspection we saw the morning medicine round started at 9.45am and finished at 11.45am, which meant some people did not receive their medicines until late morning. The nurse in charge told us some people required a lot of support when taking their medicines and we saw the medicine round was interrupted as the nurse dealt with relatives and phone calls, however we concluded if the medicine round had started earlier people may have received their medicines in a more timely way.

We looked at the medicine administration records (MAR) for eight people across both units. Generally the MARS were well completed with staff signatures showing medicines had been administered and appropriate codes used when medicines had not been given. A front sheet included a photograph of the person and clearly identified any allergies, although for one person who had been admitted at the beginning of March 2015 there was no photograph.

We saw that controlled drugs were stored securely. We checked the controlled drugs for two people and found

stock levels were correct, however administration procedures had not been correctly followed for one person. This had not resulted in any harm to the person who had received their controlled drug as prescribed, but the MAR had not been signed by the staff member when the medicine had been given. We also found the stock levels of controlled drugs were being checked and recorded daily by staff on one unit but not on the other.

We found there were inconsistencies in the use of protocols for 'as required' medicines as they were not always in place and information on the MAR was not always clear in what circumstances this medicine should be administered. For example, one person's MAR showed they were prescribed Paracetomol suspension 'as directed'. Another person was prescribed codeine phosphate 15mgs as required. The lack of clear instructions about when 'as required' medicines should be given meant people were at risk of not receiving their medicines when they needed them or being given them too frequently.

We saw some people were prescribed creams. The nurse told us that care staff applied some prescribed creams when they were delivering care and said each person used to have a chart which included a body map which instructed staff where to apply the cream. The nurse told us these had not been kept up to date and were not in place currently.

We checked the stock levels for some boxed medicines for three people and found discrepancies. For example, for one person the MAR showed there should have been 232 Paracetomol tablets in stock and when we counted them with the staff member there were only 212 tablets. This meant 20 tablets could not be accounted for. Another person should have had 32 Paracetomol tablets in stock and when we counted there were 31 tablets. A further person was prescribed Casodex 50mgs daily, the MAR showed 28 tablets had been received, 18 had been signed as given, which meant there should have been ten tablets left. When we counted there were 13 tablets left which meant the person had not been given three tablets which had been signed as given.

We saw first aid boxes were kept on both units. We asked if the contents were checked by staff as some sterile equipment such as bandages and dressings have expiry dates. Staff told us no checks were in place and we saw both boxes had no plasters in as they said these had been used by staff and had not been replaced. This presented a risk that first aid equipment may not be available to people when required or was no longer fit for purpose.

This breached Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw there were safeguarding and whistleblowing policies and procedures in place. We also saw that in the reception area there was a stand of credit-card sized cards available to take away, which included two relating to safeguarding. One was from the provider, 'When you see something wrong..... speak out.' The other was from Bradford Council 'If you or someone you know is experiencing abuse… Report it!'. Both had the relevant telephone numbers to contact.

When we spoke with care workers they told us their safeguarding training had been completed on the computer. To pass the training they had to complete multiple choice questions at the end of the session. We asked if anyone had checked their understanding and they told us this had not been done. All of the staff we spoke with told us if they felt there was anything untoward happening they would tell the nurse or the registered manager. None of them could explain what they would do if the nurse or registered manager did not respond to their concerns. This meant staff did not know how to take up issues external to the service if they needed to.

One person told us they were concerned about the safety of their belongings as they said they had had some items go missing. We asked if they had a key for their room or any lockable facility to keep things safe. They said no and said they would like to have a key but did not know if they were allowed one as no one had suggested this to them.

The operations director told us they had organised for staff to receive face to face training in relation to the safeguarding and whistleblowing procedures. This will ensure staff all know how to take any concerns to people outside of the organisation.

Some of the care workers we spoke with had not been given any training in relation to the fire procedures at the service. One care worker told us they were a 'fire warden' but had never taken part in a fire drill. We also found the fire alarms were not being tested weekly and the

Inadequate

Is the service safe?

emergency lighting had not been tested since December 2014. Following our visit we contacted West Yorkshire Fire and Rescue Service to make them aware of these concerns. They agreed to visit the service to make their own checks regarding fire safety.

This breached Regulation 23 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we visited in August 2014 we were concerned there were areas of the home that were not clean. On this visit we found the service was clean, tidy and there were no unpleasant odours. People using the service said, “It’s clean enough for me. No muck about. The cleanliness is good, I’ve no qualms about it.” “The rooms are clean.” “I’d recommend this place. Its heaven. I’ll never want to leave. I wouldn’t swop this place for anything. It’s perfect. It’s clean and spotless. My bed’s lovely. I’ve got a nice eiderdown and carpet. It’s warm and smells nice too. I can’t think of any one thing that’s wrong with this place.”

Requires improvement

Is the service effective?

Our findings

The registered manager told us that all new staff completed induction training on employment and always shadowed a more experienced member of staff until they felt confident and competent to carry out their roles effectively and unsupervised.

However, we looked at the induction plan for five new employees and found none of them had been completed correctly and in some instances the registered manager had simply written 'discussed at interview' on different sections of the plan. This matter was discussed with the regional manager employed by the organisation who acknowledged that the plans had not been completed correctly.

Three members of staff we spoke with told us they had received no training before they started working at the service. They all told us on their first day they had worked with another care worker. We saw a new care worker had started on the first day of our visit. The nurse was not expecting them and they were paired with another care worker. We saw they were left on their own on more than one occasion with people using the service.

The registered manager confirmed that following induction training all new staff completed a programme of mandatory training. We saw that the majority of training courses made available to staff were provided by e-learning which meant they completed the training by logging on to an on-line training programme. Staff we spoke with told us the only training that was not completed on the computer was moving and handling.

We saw there was an electronic system in place which monitored staff training and highlighted when refresher courses needed to be completed. The staff training matrix showed on the day of the inspection that permanent staff had completed 81% of all the mandatory courses available to them.

The registered manager told us people's understanding of the training they had completed was discussed during their formal one to one supervision meetings. However, staff we spoke with told us no one checked their understanding of the e-learning when they had finished the various courses.

The registered manager told us that the organisation's policy on staff supervision was that each member of staff attended a minimum of six supervision meetings a year (including an annual appraisal). They told us at the current time only they carried out the one to one supervisions for both nursing and care staff although this was due to change in the near future and the qualified nursing staff would take responsibility for supervising care staff.

When we looked at the staff supervision plan for the year ending the 31 December 2014 it was apparent that many of the care staff during that period had not received supervision in line with the organisation's policy. For example, the record showed that some members of staff still employed by the service had only received two or three supervisions in the twelve month period while other members of staff appeared to have had two supervision meetings in the same day or within a very short space of time.

This meant there was a risk that people were not being supported by staff who had the suitable skills and support to deliver effective care. This is because the provider had failed to make suitable arrangements for staff training, supervision and appraisal.

One person using the service explained to us, "On this floor, there are really ill people. We have one who's dangerous and really upsetting. They climbed on a table (in the dining room) and clobbered me. I'm their favourite person now and they want to come in to my room. They've upset everyone. I lock my door to go to sleep safe. You can't guide them unfortunately. Except for them, it's a very well run home. I don't think he (the manager) knows what to do with them.'

Staff we spoke with told us training in relation to challenging behaviour was completed on the computer and no practical training was provided.

We saw one person becoming very unsettled in the dining room on the first floor. They were very agitated and started shouting at other people in the room and other people started shouting back at them. There were some staff in the room but they were standing together in a small group. One member of staff said, "There's no need for that (name)," but apart from this there was no intervention by staff to settle the situation.

This showed us care workers did not have the skills or experience to respond appropriately to behaviours that challenged the service.

Requires improvement

Is the service effective?

This breached Regulation 23 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We saw there were people using the service who were subject to authorised deprivation of liberty. We found that the requirements of the Mental Capacity Act 2005 deprivation of liberty safeguards and imposed conditions in the authorisation were being met.

We saw that care plans recorded whether someone had made an advanced decision on receiving care and treatment. The care files held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. The correct forms had been used and were fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the healthcare professional completing the form. We spoke with staff who knew of the DNACPR decisions and were aware that these documents must accompany people if they were to be admitted to hospital.

People told us they liked the food. One person said, "I have a great breakfast. Sometimes I'll have a bacon sandwich, sometimes a bacon toastie. Whatever I ask for I get." This person told us they liked to have their own pot of tea and we heard the chef telling them they'd make sure it was 'nice and hot just as you like it'. Other comments from people using the service included:

"I take whatever's there, take what there is. There's plenty, second helpings if you want."

"I have no qualms about the food. I have choice and can ask for a bacon toastie."

"It's a bit of a delicate question. Breakfast is really good. Other meals – we get enough certainly. I put on weight at first."

"The food is lovely."

On the ground floor we saw people coming in for breakfast were able to help themselves to juice from a drink dispenser. Tables were well laid with tablecloths, cutlery, cups and saucers and condiments and the menu was displayed on the wall.

On the middle floor we noted the tables were only set with tablecloths and serviettes. No one was offered a choice of breakfast and people were given porridge or cereal followed by toast. Some people were given a bacon sandwich. No one was offered any sauces or salt and pepper. At lunchtime, again people were not all given a choice of meal.

When we spoke with the chef they told us people could have what they wanted for breakfast and these would be made to order. The chef told us how they fortified the food to make sure people had a high calorie diet an about the special diets they were catering for. They also told us about 'The Resident of the Day' initiative. Their role in this was to find out an individual's favourite meal, the chef told us they would use this to prepare the individual's favourite meal for a special occasion.

We saw people's weights were closely monitored and if anyone was losing weight systems were in place to make sure the kitchen staff, GP, dietician and care workers were informed. We saw in February 2015 people were mostly maintaining or putting on weight.

When we arrived on the first day at 7:10am no one on the middle or top floors had been given a drink by the night staff. On person at 7:15am told us, I could do with a cup of tea." At 7:55am another person said, "I wish they would bring me something to drink, I am thirsty. "On the middle floor the nurse in charge told care workers at the 8am handover to make sure people were given a drink. It was 8:30am before care workers made the tea. We looked at the surveys which people using the service had returned since December 2014 and saw these comments; "Have more cups of tea." "More regular cups of tea or tea making facilities for residents to use."

When we looked at people's care files we saw people had been seen by healthcare professionals such as GPs, community matrons and podiatrists. We spoke with one of the community matrons who told us they had no major concerns but felt staff did not always have time to do everything. This meant, for example, their requests for routine urine samples had not been completed. One visitor we spoke with told us they had no concerns about their relative's healthcare needs being met. They said staff were vigilant and knew when their relative was unwell.

Requires improvement

Is the service caring?

Our findings

People spoke positively about the staff. We spoke with one person who had only recently come to the home and asked how they were settling in. They said, "Everyone's very nice which has made it a lot easier. I've never been anywhere like this before but I like it." Another person said, "For me it's wonderful, all hunky dory." Another person told us they were, "Very happy" in the home.

We saw staff were kind and considerate in their approach and spoke to people by name when they came into the room. We saw staff crouching down to talk to people so they were at the same eye level and giving people time to answer. We saw staff knocking on doors before entering rooms even when doors were open. Both staff members we spoke with said they would be happy for their relative to be cared for in the home. One staff member said, "I think the care's very good here. It's all about them (residents). They want to be treated just the same as us with respect and kindness, it's just that they're older."

We spoke with one care worker who told us how they used information about people's life history and interests to engage them in conversation. Another care worker was able to tell us about three people's backgrounds and interests. This showed a person centred approach to supporting individuals. However, we saw not all of the care files contained this information.

We also saw some practices where people's privacy and dignity was not maintained. We saw staff hoisting one person from their chair into a wheelchair in the lounge. As the person was raised in the hoist it was evident the sling was not fitted appropriately and the person's clothes were displaced exposing a large expanse of their back. We saw the person was uncomfortable, anxious and calling out, yet staff did little to reassure them other than tell them they were all right which they clearly were not. We saw this person at regular intervals throughout the day and heard them repeat the same phrase at regular intervals. On occasions they appeared to be in discomfort when speaking this phrase and we saw staff responded and asked if they were all right and if their stomach hurt. When the person indicated their stomach did hurt staff again comforted them but did nothing else. When we asked staff about this, they said the person always said the same phrase to everything. We later saw this person in bed after they had been hoisted and they were lying on their side facing the wall with the light cord hanging just inches away from their face. They were saying the same phrase and holding out their hands. When we asked if they were in pain they said yes. We told the nurse who came to see the person who confirmed they were in pain and the nurse said they would bring them some analgesia. The nurse adjusted the bed so the light cord was still in reach but not directly above the person's face.

One relative told us, "Some staff appear not to care they are always on mobiles and chatting instead of taking care of residents. Residents are left sitting in dining room long after meals have finished, whilst staff laugh and joke, ignoring their needs. Residents often have food spills on their clothing."

We saw staff standing together during our visit when they could have been spending time with people who used the service.

We saw some care workers were not very good at engaging with people. At breakfast time on the middle floor care workers came in and out of the room without speaking to people. One care worker put the radio on without asking people in the room if they wanted it on. The 'Pulse' radio station was playing. The nurse asked for the music to be changed to something more appropriate and staff ignored them. The radio station was only changed when the nurse asked a care worker by name to do this. One care worker told another care worker, "Sometimes she does and sometimes she doesn't." Referring to someone eating their food unaided. The same care worker's mobile phone also went off. The nurse reminded them their phone should be turned off.

We saw one person sitting at the dining table who looked very uncomfortable. They had been sitting at the table for two and a half hours and had slipped down in their chair. Care workers made no attempt to move them or make them more comfortable. The person was only moved to the lounge when a visitor told care workers the person, "Would be under the table soon," if they did not do something.

This breached Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visitors we spoke with told us they were made to feel welcome. One relative said, "Café Amore is a really nice place for people to go and sit with a coffee."

Requires improvement

Is the service responsive?

Our findings

We looked at nine people's care records. We looked at the care plan for one person who had recently moved into the service. We saw they had a care plan in place which reflected the care and support care workers needed to deliver. We saw they had put on weight and had settled well. One care worker we spoke with told us how they were meeting this person's needs and how they had helped them to settle in.

One visitor told us, "X's only been here one week and I think its very good. X's come on leaps and bounds. When they arrived here they couldn't walk at all. Now they are walking around with just a stick. What I like is that if you ask anything you get a straight answer. Particularly about what's best for X. X's well looked after and gets good nursing care. They had a birthday last week so they baked them a cake and yesterday they put up a bird cage feeding tube just outside their bedroom window."

However, we found care plans and risk assessments were not always in place to direct and support staff in how to provide care and support. For example, one person's notes showed they had unpredictable epilepsy, were unable to use a call bell, had a catheter, required help with eating their meals and sometimes displayed behaviour that challenged others. There were no care plans or risk assessments in place for these needs, which meant staff were not provided with information about how to support this person with their care needs. There was a care plan for mobility and this said to encourage the person to use their call bell. However, when we spoke with the person they were unaware of the call bell. They told us if they needed staff they had to go to the door and shout and we saw and heard this throughout the visit.

There was a risk assessment in another person's records which stated bed rails were not appropriate, yet we saw bed rails were in place. This person was assessed as nutritionally at risk and the care plan stated they were to be weighed weekly, yet the last weight recorded was 13 February 2015. None of the care plans for this person had been reviewed or updated since December 2014, although notes showed there had been changes in the person's condition since that date.

We saw one person's recent needs assessments showed they were at high risk of developing pressure ulcers, were nutritionally at risk and were a low weight. The records showed this person had a pressure relieving mattress in place as a preventative measure. We saw this person was in bed and the mattress was set at 60kg. The person's weight was last recorded on 3 March 2015 as 48.2kgs. This meant the mattress was not set correctly and therefore would not be working effectively to relieve pressure thus increasing the person's risk of developing a pressure sore.

We saw one person had been admitted at the beginning of February 2015. Records showed this person required specialist nursing care from staff skilled in managing behaviour that challenged others. Staff told us they had received no training in managing this type of behaviour and were unsure how they should handle these situations when they arose. There were no care plans for this person which meant staff were not provided with information about how to approach and support the person to help them avoid potentially challenging situations.

We observed one person being hoisted by staff and the sling used was not appropriate as the person was not secure. We looked at this person's care records which showed the person became immobile in October 2014, yet we found the moving and handling assessment and care plan had not been updated and there was no information about the equipment needed to move the person safely. This person had fallen in February 2015 yet the risk assessment had not been updated since December 2014 and neither had any of the care plans.

Another person who had been admitted in January 2015 had complex health care needs, including dementia, weight loss and a history of falls yet there were no care plans and many of the risk assessment forms had not been completed.

We saw two care workers assisted one person out of a wheelchair using an inappropriate lift. We brought this to the attention of the nurse who was present in the room. The nurse told us the individual needed the hoist to transfer them safely. We looked in this person's care plan and saw the moving and handling assessment had not been updated to inform staff the safe way to transfer this person.

The absence of up to date care plans meant there was a risk of people not receiving safe and appropriate care and support.

Requires improvement

Is the service responsive?

This breached Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the complaints procedure was on display in the main entrance and was included in the service user guide. We asked people using the service if they knew how to complain. One person said; "There's nobody specific to go to." Another said "I'm not quite sure where to complain – the head of department?" We spoke with three relatives who told us they had made complaints to the registered manager but had not received a response. One relative said, "It's a waste of time complaining because they (the registered manager) don't do anything." We looked at the complaints file and none of these complaints had been logged. This meant people's concerns were not being dealt with and resolved.

This breached Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. which corresponds to Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people about the activities that were available. These were some of the things people told us: "We have a number of regular events, for example, parties, sing-songs. I've always been impressed – they've brought classes of infants to join us. I enjoyed that. They sit on the floor, sing, play about. Art Class is every week – a teacher from a school comes." "I go to everything but the vehicle is not very big so I have to be careful not to be greedy." "There are not a lot of activities, it's winter now. We're a bit short on physical activities. I wouldn't mind some exercises. We can have a long walk on our own if we want to." "I'm bored. There's nothing to do, I just watch TV and wait for my family to visit. Staff are nice but there's not enough of them and they don't get time to talk." "There's always loads going on and every day too. There's arts and crafts, films, photographic exhibitions of old Bradford, baking, trips out to the pub, Haworth and the museum."

The Head of Activities told us that there were three separate activity programmes for the three floors but they sometimes came together, for example, one person who lived on the top floor joined the art class on the ground floor. Anyone could go on the trips out and families were encouraged to join too. There were two part-time Activity Organisers, one of whom was a volunteer. External people were brought in for art and music sessions.

The service had its own minibus and this was much appreciated by people who told us how much they had enjoyed a recent outing to a restaurant which was available to all if they wished to come.

During breakfast, we saw everyone received a newsletter in large print with 'On this Day' history information and quizzes. People confirmed they received this each Monday. In the lounge, we saw several newspapers and a large fish tank. The flat-screen TV was set at a reasonable volume that did not prevent conversation and other activities.

The service also had a dementia café 'Café Amore' on the first floor which was run by volunteers and was open from 11am or 12 to 3.30pm or 4pm every day. A member of staff told us that it also helped families as they met each other there. One person told us, "Some feel forgotten and lonely in their rooms. The café on the first floor – I'm made very welcome there."

On the second day we saw a number of people involved in St Patrick's day celebrations. A singer had been booked and Guinness and other alcoholic and non-alcoholic beverages were available. We saw people were singing along and enjoying this entertainment.

Inadequate

Is the service well-led?

Our findings

We received mixed reports about the registered manager from staff. Some told us they were approachable whilst others told us they were not. We found some staff did not feel relaxed when they were speaking with us. Some staff prefaced the conversation with, "Will we get into trouble for speaking to you?" One member of staff said, "The manager 's alright but is too laid back. They make promises but they don't materialise. We've raised an issue with them about twelve months ago. They said they would investigate but nothing's happened."

On the second day of our visit some staff asked if they would, "Still have a job at the end of the week?" One member of staff reported the registered manager had shouted at them following our visit on the first day. Another member of staff told us they were often short staffed and the registered manager had said to them, "Blame your colleagues for being off sick." Another member of staff told us when they had tried to contact the registered manager because they were short of staff the registered manager had not answered their phone.

One visitor said, "Occasionally I see the manager walking around the place talking to staff. I don't see them often. I think they should be more involved."

This meant the culture of the management of the service was not open, honest and responsive.

When we visited in August 2014 we asked the provider and registered manager to make improvements to the assessment and monitoring systems they were using. We saw evidence that audits and checks were undertaken however we concluded that the quality assurance system was not adequate given we identified numerous breaches of regulations. The problems we found with care quality, medication, dignity and respect, staff recruitment, staffing levels, staff training, complaints management and records should have been identified and rectified through a robust programme of quality assurance.

We saw monthly medicines audits were undertaken by the registered manager. We looked at the audits for the last four months, which identified no actions other than ordering new pharmaceutical reference books as the existing ones expired at the end of March 2015. The audits had not identified the issues we found at this inspection.

We looked at the monthly safety, quality and compliance meeting reports and found six reports had been completed since May 2014. We saw training needs in first aid, managing challenging behaviour and cardio-pulmonary resuscitation (CPR) identified in May 2014 as outstanding were still recorded as outstanding in the most recent report in February 2015 with no further information on actions being taken to address this.

We looked at the fire safety records. We saw a fire risk assessment dated 10 December 2013 which identified actions to be taken by the provider. In response the registered manager had compiled an action plan with timescales for completion in 2014 yet we saw some actions were not recorded as completed. Quarterly fire door checklist sheets had not been completed. There was only one in the file which was undated but an entry said work had been done in March 2012.

At the previous inspection we identified night staff had not taken part in six fire drills a year which had been stated as a requirement in the operations manager's report. We looked at the fire evacuation records which were to be completed after every fire drill and false alarm. These showed only two drills had taken place since July 2014. One of these had been at 6.45am and involved the night staff. The form stated, "Two staff did not attend, one alone on the top floor and one remained on the ground floor. Staffing levels prevented any attendees from the top floor."

Weekly tests of the fire alarm system were inconsistent with a gap of three weeks between the last test and the one recorded previously. Monthly emergency lighting tests had not been completed since December 2014.

When we asked we were not provided with up-to-date certificates for the electrical wiring installation or gas safety. We saw a gas safety advice note dated 2 June 2014 which identified works that needed to be completed but there was no evidence to show this had been done.

We looked at the monthly operations director's reports for the last three months. There were two reports completed in December 2014, one contained actions with timescales for completion. For example, to ensure all fluid charts were totalled was one action. The other three reports stated there were a number of areas not completed in the reports and these would be reflected in the following month's report. We found this was not happening and the same areas had not been completed on all three visits. We

concluded the reports were not effective as they failed to identify the issues we found at the inspection and had not checked that actions had been completed. For example, we found the fluid charts were not being totalled by staff.

We looked at the assessment tool that was being used to determine staffing levels. This clearly stated the registered manager should get authorisation from the provider if staffing levels needed to be increased in order to make sure people's needs were met. This had not been done and from the duty rotas we saw staffing levels had not been maintained at the very minimum at times.

We looked at the accident and incident analysis that was completed at the end of each month. We found there was a comment against each fall, for example, but no actual analysis. We noted there had been six un witnessed falls that had all resulted in people breaking a bone. There was no analysis to see if any trend could be identified or what measures could be put in place to reduce the risk in the future.

This breached Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The night staff told us there should be two nurses and six care workers on duty at night but said they were frequently short of staff. We asked the registered manager for the duty rotas and were given printed copies which they told us were the 'worked rotas' which were submitted to payroll. These showed a number of shifts where these staffing levels had not been met. We were then told when staff from another of Amore's services covered they were not put on the rota and were given their individual timesheets to show which shifts they had covered. The registered manager also contacted the agency to get them to send details of agency workers that had covered the night shifts. This meant there was no accurate record being kept of who had worked on any given day. We spoke with the operations director who told us rotas should clearly show who had worked on each shift and in what capacity.

We looked at the food and fluid charts for one person who was assessed as nutritionally at risk and had a low weight. Many of the charts were undated and we found two charts with the same date on which gave different information about what food and drink the person had consumed. The charts did not have information to guide staff on how much the person should be drinking in a day and the fluid intake had not been totalled on any of the charts we saw. We noted from the weight audit for February 2015 this person had gained a small amount of weight, however, records were not being maintained or checked to establish if their food and fluid intake was adequate on a daily basis.

This breached Regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the second day of our visit the operations director took immediate action to strengthen the management of the service. They gave us verbal assurances about what they would do to bring about immediate improvements. They followed this with a written action plan which identified where improvements had been made and how they were working towards improving other areas. This showed us they were being pro-active and wanted to make sure improvements were made quickly.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **People who use services and others were not protected against the risks of being cared for by unsuitable staff because had failed to fully explore the suitability of staff before employing them.** **Regulation 19 (3) (a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **People who used the service were at risk because there were not enough staff to care for them and keep them safe. Regulation 18(1)** **Staff had not received appropriate training to enable them to deliver care safely and to an appropriate standard. Staff had not received appropriate supervision, professional development or appraisal. Regulation 18(2)(a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person did not ensure there were suitable arrangements for the safe administration of medication.** **Regulation 12(2)(g)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

This section is primarily information for the provider

Action we have told the provider to take

Treatment of disease, disorder or injury	Suitable arrangements had not been made to ensure people's privacy, dignity and independence were maintained. Regulation 10(1) & (2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People who used the service were at risk from not receiving care that met their individual needs or kept them safe. Regulation 9 (1)(a)(b) & (3)(b)

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints Suitable arrangements to recognise and respond to people's complaints had not been made. Regulation 16 (1) & (2)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance People using the service were not protected against the risk of inappropriate or unsafe care and treatment because the quality systems were not effective and risks were not being identified or managed. Regulation 17 (1) & (2)(a) & (b) Suitable arrangements had not been made to ensure accurate records were maintained. Regulation 17 (2)(d)(ii)

The enforcement action we took:
Warning notice to be met by 31 July 2015