Care Homes UK Ltd

# Haven Lodge

## Inspection report

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13 July 2017

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

The inspection of Haven Lodge took place on 11 and 13 July 2017 and was unannounced. The home had previously been inspected in January 2016 and was rated good.

Haven Lodge provides accommodation and personal care for up to 32 people in single room accommodation. The home is located in the village of Normanton on the outskirts of Wakefield. The home has accommodation over two floors, accessible by stair lifts. Communal lounges, a dining room and bathing facilities are all provided. There is a small garden to the rear of the building. There were 32 people resident in Haven Lodge on the days we inspected.

There was a registered manager in post and they were available on both days of the inspection. 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.

People and their relatives told us they felt safe and staff knew how to support them safely.

We found serious issues with the assessment and management of risk, as documentation did not provide sufficient guidance for staff in how to minimise the likelihood of harm. Not all staff appeared confident in moving and transferring people safely and we observed some poor practice.

Staff were stretched as on the first day one care worker was off sick and the registered manager spent part of the day shopping for groceries for the home. People displayed high dependency needs and many needed the assistance of two staff to transfer safely, but this was not reflected in staffing levels.

There were numerous issues with medication including administration, storage and record keeping. Where issues had been noted, it was not evident they had been addressed and audits proved inaccurate tools to assess competence.

Supervision and training was available to staff although some of this had been acquired with previous employers. Recruitment checks also raised issues as these were not followed up appropriately.

People were not always supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice.

There were issues in the home for the support of people with nutritional needs as staff were not aware of how to support effectively, and guidance from dieticians was not always followed.

People were able to access external health and social care support as required.

Staff were caring, kind and compassionate despite being under considerable pressure. They acknowledged people and spoke fondly to them, engaging in conversations where time allowed.

People and relatives felt included in decisions about their care although the written evidence was not always evident.

Activities were non-existent as staff were unable to offer extra support as they were too busy providing care support. People and relatives did speak positively of options usually available.

Care records provided contradictory information or in some cases, not enough to minimise risks to people. Evaluation records, although completed, did not always reflect changes in people's needs.

Complaints were handled well.

The home had a pleasant and friendly atmosphere which was evidenced in the positive interactions between people and the staff.

The registered manager was new to their role and appeared to lack experience. Due to the number of concerns we identified we found the overall management and leadership lacking as staff needed support but did not receive it and the quality assurance processes were not effective as issues were not addressed or actioned.

The overall rating for this service is 'Inadequate' and the service is therefore 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.

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.

Risk assessments did not provide sufficient guidance for staff to assist people safely.

Staffing levels were not sufficient to meet people's needs and medication was not stored, recorded or administered safely.

People told us they felt safe as staff knew how to respond to concerns.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

People at nutritional risk were not always supported effectively, and consent for people who lacked capacity was not obtained in line with the Mental Capacity Act 2005 requirements.

Staff were supported with regular supervision and training was provided.

We saw evidence of close working with the community nursing service and other professionals as required.

### Is the service caring?

**Good**

The service was caring.

Staff displayed positive caring attitudes towards people despite being under pressure.

People and relatives spoke highly of the care staff and felt included in the care delivery even if this was not always recorded.

People's dignity and privacy was respected most of the time.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Although we observed limited activities for people, people spoke positively of things they had done.

Care records were lacking in detail about how to meet people's needs and evaluations did not reflect changes in people's conditions.

Complaints were handled well with investigations and agreed outcomes.

## Is the service well-led?

**Inadequate**

The service was not well led.

People and relatives expressed their happiness with the atmosphere of the home, and how they felt included in decisions.

However, we found serious concerns in the overall management and scrutiny of quality assurance information which meant we had little confidence risks were being managed safely or effectively.

# Haven Lodge

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 11 and 13 July 2017 and was unannounced on both days. The inspection team consisted of two adult social care inspectors who were present both days, and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience had detailed knowledge of care services for older people and those living with dementia.

We had requested a Provider Information Return (PIR) before 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. We checked information held by the local authority safeguarding and commissioning teams in addition to other partner agencies and intelligence received by the Care Quality Commission.

We spoke with 15 people using the service and four of their relatives. In addition we spoke with six staff including two care workers, one senior care worker, one of the kitchen staff, the deputy manager and the registered manager. We also spoke with a visiting health professional.

We looked at 11 care records including risk assessments, five staff records including all training records, minutes of resident and staff meetings, complaints, safeguarding records, accident logs, medicine administration records and quality assurance documentation.

Inadequate

# Is the service safe?

## Our findings

One person told us, "I feel very safe as the staff look after me really well," and another said, "This is a very safe place. It's very good here. My family are happy that I'm being well looked after." A further person also stressed, "'I feel very safe. Staff are there when you need them but I do everything for myself. I don't need my hand holding all the time."

We looked at safeguarding records and found in general referrals were made as required, with necessary investigations and actions being taken. Staff understood how to report such concerns and what sort of events may require this. However, we did find one recent incident which had not been investigated and we spoke with the registered manager about this and they agreed to look into it.

Accidents and incidents were logged and recorded on specific forms. Although people received prompt treatment for any injuries such as skin tears, there was limited analysis of such events and no evidence future risk reduction measures had been considered. Two people had obtained skin tears as a result of their legs catching the footplates on wheelchairs but we could not see any evidence staff had been offered further training around safe moving and handling practice.

We observed a mixture of good and inappropriate moving and handling of people during our inspection. Not all staff demonstrated they had a clear understanding of how to use equipment in ways which kept people safe. On each day of the inspection we observed staff assist one person to transfer. Staff used the equipment differently each time, and straps were fastened too tightly which caused the person visible discomfort. We observed two other people who were handled by care staff without consideration for their comfort. This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment as staff did not show competent moving and handling skills.

Risk assessments did not always reflect people's needs and provided conflicting guidance for staff to show how risks could be minimised. One person's record indicated they had variable mobility but only referred to the use of a wheelchair and that staff were to assess each time the person's ability to move safely. There was no other guidance stating which equipment was to be used. Another person's care plan referred to the use of a wheelchair and a stand-aid, but with no guidance for staff as to the safe method of transfer.

People's personal emergency evacuation plans (PEEPs) did not always match the records in people's files. In one person's care record the PEEP was dated December 2015 with a comment saying the person was able to accompany staff to a place of safety independently, however their mobility and dexterity assessment dated June 2017 stated they needed assistance for transferring and walking as they were unable to mobilise on their own. For another person on permanent bed rest there was no mention of specific moving and handling needs. This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment as the assessments of risks did not include measures to reduce the likelihood of harm.

Two members of staff brought another person into the lounge in a wheelchair, but while they were

transferring the person's legs gave way and they were lowered to the floor by staff. They were checked for injuries and none were found. The registered manager asked staff to get the hoist but they returned with the stand aid. We asked about this and were told the hoist was out of action, but staff had been unaware until they tried to move it. This is a breach of Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 premises and equipment as staff did not have access to a working hoist.

The registered manager told us two people had bedrails in place. However when we checked, we found three people did. This meant the registered manager lacked an overview of equipment in use. One person's care plan contained a risk assessment for 'falling out of bed' dated September 2016, which said the person had two hourly checks, bed rails and a profiling bed. There was a basic bed rails' checklist in their file. This was dated March 2017 but we did not see any evidence that this had been reviewed. There was no risk assessment in place for another person using bed rails which we found were not safely attached to their bed. We asked the registered manager to take immediate action about this. When we asked what checks took place for bed rails the registered manager was unaware of the guidelines in place or what checks needed to be conducted. This meant staff were unable to assess for risks to people from equipment as no guidelines were in use.

We also identified some maintenance issues during our inspection which had not been addressed in a timely way. For example, checks in May 2017 had identified a stop was missing from the weighing chair which was still missing on the day of our inspection. A missing brake from a shower chair had been identified in April 2017 but no action had been taken to repair this. These examples were a breach of Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 premises and equipment as equipment was not being properly maintained.

We asked people about staffing levels and received mixed feedback. One person told us, "Mostly there's enough around to help" and one relative said, "My relative has never complained about having to wait for help." However, another person said, "Occasionally they seem a bit stretched and I have to wait." A relative said, "I have absolutely no concerns about her safety. I can't praise the home and the staff enough. We looked at four or five homes and this one ticked all the boxes. If I've any criticism, it's that they are short staffed. That's not the staff's fault. They are wonderful but they can't see to everybody at the same time."

Another relative told us, "I do think they are short staffed. The staff are all lovely but they are overstretched." Another relative also spoke with us about staffing concerns, "Standards have deteriorated. It's all to do with staffing levels." A further relative said, "The only problem is that they are overstretched. They work ever so hard. I'm not faulting them, but they just can't do everything."

During our inspection we heard call bells ringing at frequent intervals for much of the first day, and saw people frequently had to wait for assistance to the toilet for over ten minutes. We observed one person wait 50 minutes for assistance. We asked the registered manager if they assessed the length of time people had to wait but they told us this was not reviewed.

On the first day we observed some people helped into the lounges between 10.30am and 11.30am, which meant they were eating a cooked breakfast at 11.30am, with lunch provided only one hour later. We asked staff how this was managed for those people who preferred to have late breakfasts and were told, "It's a bit difficult and some people tell us to save it (lunch) for later."

One staff member told us there was usually one senior and four care workers on duty during the day, three care workers at night and the activity co-ordinator who worked weekdays between 10am and 4pm. However, they said, "It's been very hard recently as two staff have left and there are not enough. Staff don't

want to pick up extra hours." This view was echoed by another care worker who said, "Staffing has been low due to sickness and holidays. A few weeks ago there were only two of us in during the afternoon which was hard." We observed the care worker administering medication was constantly interrupted due to the telephone ringing and having to deal with other issues. They explained part of this was because one staff member had called in sick that morning.

The registered manager said the home used a dependency tool which was evaluated monthly and allocated number of hours per shift. We could not find any assessment of people's individual dependency needs in their files.

We found the rotas did not always show the home was staffed to the levels the registered manager told us about. They told us there were four care staff on duty each day, however in the sample of rotas we checked there was only one day out of ten when this was the case. The registered manager told us a number of staff were on sick and were others on leave, and some new care staff were currently undergoing pre-employment checks. They were not able to tell us why some shifts were not fully covered.

The registered manager advised us some staff working at night had not been trained to administer medicines which meant people could not receive medication during this period. They told us they relied on senior care staff administering medication before leaving the day shift and this meant if people needed pain relief medication no one was available to do this. We concluded the provider was in breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 staffing as there were not sufficient numbers of staff to meet people's needs promptly.

We checked staff recruitment files and found these did not always contain appropriate background checks. In one file no dates of previous employment had been given, and the interview notes did not indicate this had been queried. Some references had been accepted from family or friends which had not been verified. In another file concerns from a Disclosure and Barring Service (DBS) check did not appear to have been addressed although the registered manager assured us a conversation had been held. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 good governance as checks were not comprehensive enough to provide guarantees about staff's suitability to work with vulnerable people.

We asked people about the support they received with their medicines. One person told us, "They watch me while I take the tablets and bring me some water with them." Another person said, "They always bring me my tablets in the morning, at lunchtime and at bedtime. I don't worry about it." We observed the care worker support people with their medication patiently and sensitively, always ensuring the person had taken all their medication.

We found a number of issues with medication in relation to administration, storage and recording. Some people had not received their morning medication by midday on 11 July 2017 as they had been asleep, and one person had been given medication a few minutes before eating a bowl of cereal which was supposed to be given at least 30 minutes before any food. Medication which had been prescribed as PRN or 'as required' did not always have guidelines for staff to follow in relation to dosage, timing between doses and when it should be given. Some records were completed but others were not, which meant staff were unclear who had received medication and when. This meant staff were at risk of overdosing people by giving medication too close together or not ensuring pain levels were managed effectively as medication was not evenly spaced.

We noted on one person's medication administration record (MAR), a medicine was recorded as 'W'. When we asked staff what this meant they told us 'withheld' which would normally be used if a person was unwell but it was actually because the home had run out of stock. We were told the prescription had lapsed and this had been missed by the home when booking in medication. This had also happened for two other people in relation to their medication.

Another medication which had clear instructions saying, 'Do not stop unless on advice of the GP' had not been administered on three occasions in the past two weeks. This could have caused serious harm to the person. Although the care worker told us the GP had said this was acceptable, there was no medical note to support this discussion. We found three medication administration records did not have signatures against them indicating they had been administered. When we questioned the care worker they told us they had forgotten to do so.

Topical creams were not always stored safely as a locked trolley was kept in the corridor all day when some creams should have been stored in the fridge. We did not find body maps to assist staff in where to apply creams or other topical medication, opening dates of creams were not recorded so it was difficult to determine if they had exceeded their use by date and records were not completed in full to show creams had been applied.

Medication was stored in the medication room where the temperature had been recorded at over 25 degree centigrade for the previous five days. This exceeds the safe guidelines for storage of medication, but we could see no action had been taken to remedy this. We checked staff training records and competency checks and found these had either not been completed or were inaccurate in the information recorded as questions which should have been marked 'no' were marked 'yes'. This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment as medicines were not managed safely.

Requires Improvement

# Is the service effective?

## Our findings

People felt staff were well trained. One person said, "They are very good. They are very careful if they help me to stand up."

One care worker told us they had completed one full day's induction, shadowed day shifts and also one night shift. They advised us they had been given in-depth instructions on the fire procedure. We saw the induction consisted of procedural instructions for staff including an outline of equipment used, the importance of promoting dignity and respect for people, accident reporting requirements and infection control policies. This checklist was signed by employee and manager. However, other staff had not received an induction and we did not see any evidence of an induction or training where one staff member moved roles to a caring capacity.

Staff had received regular supervision and told us they felt supported in their role. A member of staff said, "I have regular supervision and have had an appraisal. I just tell the manager if things are not right until it gets sorted." Supervision records in staff files showed staff had received quarterly, topic-based supervision with the opportunity to raise any other issues. We also saw appraisals which included the employee and the manager's view of their performance, and provided positive feedback for staff.

We saw in staff files people had received training in medication (where this was part of their role), safeguarding, infection control, fire safety, health and safety, food hygiene, dementia awareness, and privacy and dignity. Some of this training was supported by a post course questionnaire to embed the learning. The regional manager was aware of staff whose training had lapsed and was regularly checking records to see if this had been remedied.

We asked people if their choices were respected. One person told us, "I come in here (the lounge) in the morning. It's always up to me." Another person said, "They are always asking me first. When they come in to make my bed they ask if it's okay." A further person told us, "They are very polite and never take things for granted." Relatives also echoed this view. One told us, "They always talk to [name] about what they want and if there are any doubts they will contact us. We spent a lot of time going through their likes and dislikes when they first came here."

We asked people if they were supported to make their own choices. One person told us, "I can go to bed when I'm ready and get myself dressed so I choose my clothes, I like to look smart." Another person said, "No-one bothers me and I can do just what I want. They don't pamper me and they look after me as though I'm an adult."

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The few mental capacity assessments we found were dated 2015. There was no evidence of decision specific tools being used to obtain the appropriate consent for care intervention. One care record indicated a person had good recall and knew where they were and yet a DoLS was in place indicating they were totally dependent on staff for all hygiene, nutritional and mobility needs. This meant the care plan was an inaccurate assessment of their abilities.

Another person's care plan for medication showed they were unable to self- medicate due to their mental health condition but no appropriate consent had been obtained for this person. Again, it was recorded they were able to make their needs known in their cognition care plan. This care record also stated they were unable to hold a key for their room due to their mental health and yet no assessment had been completed to make this decision on their behalf.

The care worker administering medication advised us of one person on covert medication as they were reluctant to take any medication. However, when we looked at their records we could find no evidence of any decision-specific mental capacity assessment or best interests' decision where this had been agreed with the relevant parties including the pharmacist. This showed a lack of understanding and contradiction of assessment around the requirements of the MCA. This is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 need for consent as there was a lack of mental capacity assessments in place for people unable to make specific decisions.

The home had eight DoLS authorisations in place and was awaiting the outcome of a further five applications. The registered manager said there were a further six people who needed an application. Out of the eight authorisations in place four had conditions attached which the registered manager had no awareness of and they had not been implemented as required.

Where people had their liberty restricted through the use of bed rails, we found a DoLS in place, but no corresponding mental capacity assessment or best interest decision to agree this was appropriate. Another person's care record indicated a DoLS was in place but this had not actually been authorised. One care worker we spoke with was not able to explain if anyone was subject to a DoLS as they had never received training in this area, however, another care worker was aware of the implications of a DoLS although did not know who had one in the home. This is also a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 need for consent as conditions of DoLS were not being adhered to.

People spoke positively about the food. One person said, "I've no complaints about the food. They come round in the morning and tell us what is on so I can choose. It's always very good." Another person told us, "I like the food." A further person said, "There are always two options at lunchtime. I don't know what would happen if I didn't like either of them. It's not happened because I'm not funny about food."

The menu in the kitchen differed from what food was offered to people. When we asked why, we were told the part of the oven was not working but this had been reported. The kitchen assistant advised us people were offered fruit mid-morning and had a selection of cakes in the afternoon. They were unaware of who was on a special diet due to a medical condition such as diabetes or had difficulties swallowing, or was at risk of weight loss. They explained staff would tell them if there was anyone they needed to know about. We

observed people asked their preference for the main meal but no picture cards were available to assist choice.

Despite being advised lunch was served at 12.30pm no food appeared until 1pm and we heard people commenting on this. Most people stayed in the same chairs where they had been all morning. There was little social interaction between people. Four people moved from one lounge to the other to sit at a table and two other people went into the dining area. Tables in the dining area were set with cloths and cutlery; everyone else had wheeled tables put in front of them. Some people were provided with cutlery while others were not, although we saw cutlery was available on a trolley brought into the dining area. We did not observe anyone being asked if they would like a clothes protector although three people had them applied.

Some people were not offered any drinks until most had finished their meals and no choices were offered as there was only orange squash available. We observed one person had to wait over 20 minutes for their meal while others at the table ate theirs, and others made comments about the food being cold. People did not have access to any condiments and they were not offered when requested.

We saw one person who needed assistance to eat. A staff member approached and gave the person a spoonful of food while standing over her. The staff member then went off to do something else before returning to give another spoonful of food. After another interruption they returned and sat down with the person. The person asked if there was any more gravy but the staff member ignored this question and continued to offer food, saying, "Let's see how we go." Another person from a neighbouring table who needed assistance as they tried to eat their pudding, spilt it but no staff were available to offer help.

We looked at records of people who were at nutritional risk. One person's record showed conflicting weight amounts for the month of June 2017 ranging from 52.3kg to 48kg. We saw they had been referred to the dietician by the GP and prescribed supplements. However, the home did not have these in stock due to a prescription error. We also saw this person offered a drink and some biscuits but refuse them. Instead of the care worker trying to encourage them, they said 'OK' and walked away. Another person with low body weight had been seen by the dietician who had recommended various actions. However, upon checking their records we could not see these had been carried out and they were deemed at low risk.

Food and fluid charts were not completed consistently. Only three charts were found for June 2017. The charts did not total people's daily food or fluid intake which meant any potential concerns could not be addressed. We added the totals of fluid and found one person had as little as 260ml of fluid over two separate days in June. This had not been highlighted in any records. Another person on bed rest complained of being hungry and thirsty at 2.55pm and we saw they had no access to a drink. We requested this and staff brought it. We were advised people's food and fluid charts were subject to regular scrutiny by senior care workers and senior managers.

Staff did not have a clear understanding as to the use of thickening agents to minimise the risk of a person choking or who was prescribed them. We spoke with three staff who gave us conflicting information as to the required amounts for people. We found a tin of 'thick and easy' on a trolley with no label attached and sachets in the kitchen. A member of care staff told us the pharmacist had delivered these for general use. There were no records to show where thickening agent was used for people and we could not find any records from the Speech and Language Therapy team to identify who needed this. This meant staff did not have the necessary information to use thickening agents safely. This is a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as not all people were being supported appropriately with their nutritional and hydration needs.

We saw people had access to external health and social care support as needed, and these needs were monitored on a monthly basis. We spoke with a visiting health professional who assured us, "staff were always available to support them, and were very responsive in alerting them if they noticed a reddened area on a person." They had confidence the registered manager was aware of what was going on in the home and people's weights were monitored closely.

Good

# Is the service caring?

## Our findings

People spoke highly of the care staff and said they felt comfortable with everyone as all staff listened to them. One person said, "They're all lovely with us. They are really super lasses," and another echoed this, "They're all so nice to us. They're very nice staff." A further person said, "They can't do enough for you. They are very kind."

One relative said, "They do look after her really well and the staff are very kind." Another relative told us, "The staff here are really good. They do try their best and visitors are made very welcome as well." One staff member told us, "I really like it here. Everyone is very friendly and all staff are supportive. It is homely."

We observed staff ensuring people were comfortable in their chairs, and saw one person was offered a cushion to support their back. We heard one care worker knock on one person's door before entering and wait for a reply. They greeted the person by name, "Good morning [name]. How are you?" in a very cheerful and pleasant manner. We heard the person respond similarly. Later the person was assisted to the lounge, and we observed the care worker sang to them and the person responded. Another person who thought they were returning home said to a care worker, "I shall miss your lovely face," to which the care worker replied, "I will miss yours too" with a large smile.

One person was shouting out at frequent intervals, and one care worker went to talk to them and explained in a sensitive manner how much their shouting was upsetting them and other people. This calmed the person down.

There was a friendly atmosphere in the home between staff and people, and staff showed they knew people well. The registered manager and deputy manager admired people's hair styles after visiting the hairdresser, and spoke positively to people about how nice they looked. We saw that people's hair, skin and clothing were clean. Some ladies had their nails manicured.

People told us that they were encouraged to be independent if they were able and to ask for help if required. One person said, "I can undress myself when I'm ready." People's preferences for gender of care worker were respected.

Although people we spoke with were not familiar with a care plan, families told us that they felt involved in the care of their relative and were kept informed. One relative said, "We were involved in the care plan and we have had a few meetings with the manager to review it." One person said,
"I leave it to my family. I am well looked after and that is all that matters to me."

Two people were deemed to be on end of life care in the home and we were aware the community nursing service were supporting staff.

Requires Improvement

# Is the service responsive?

## Our findings

One person said, "I really like to go into the garden. They help me to go outside when the weather is good." Another person told us, "I like to come in here (the lounge) because we've made friends so there's always somebody to chat to."

We did not see any activities and were told that the activities coordinator was on holiday. People sat in the lounges, either dozing or looking around. TVs were playing all day in both lounges but nobody was watching them and nobody was asked whether they wanted them on. People sat for long periods with no meaningful interaction. One person's care record noted how much the person did not like the television and yet they were sitting nearest this in the lounge and remained there for much of the first day of the inspection. We did not observe them being asked if they would like to move or do some other activity.

However, one person told us, "One afternoon every week different people get to go out if they want to. (Named care worker) takes you to town or to play bingo or something." Another said, "(Named care worker) does manicures and they get people round the table to play cards or a board game." A further person said, "We have entertainers sometimes and some of us play dominoes." One relative confirmed these views, "They do have things going on normally. They've had entertainers and a young couple who get them all singing the wartime songs. They've had games with balloons and scarves and at Christmas they had carol singers and that sort of thing."

We were told by a few people of a planned trip to Scarborough which they were looking forward to. We saw notices about this in the reception area along with a forthcoming band concert and also the summer fayre.

We looked at care records and found they were completed in a consistent manner which aided navigation. Records contained a photograph which assisted clear identification of the person and other key information such as any allergies and emergency contact information. There was also evidence of people's life history and important family contacts to assist staff in getting to know people. Some of this information was actioned as we saw one person liked to wear their nightclothes after lunch and they were supported to do this in a dignified manner.

Records included information about people's personal care and wellbeing, nutrition, communication, mobility, continence needs, medication, mental health and cognition, social and personal safety needs. The assessments for each domain consisted of a series of ticks to indicate a person's ability to manage a particular task which was then incorporated into a care plan. We saw these assessments were reviewed on a monthly basis. However, the care plans were often generic in nature such as ensuring appropriate footwear was worn and there were no obstacles to help people with mobility. The evaluative comments were also basic such as 'no change to care plan' which did not reflect person-centred practice. We saw this area had been noted as an area for improvement for staff following a recent provider visit.

Care records were completed for different needs but were not always accurate. One person had a pressure ulcer which was being attended to by district nurses. However, the person's skin assessments dated June

2017 indicated their skin was intact and the corresponding care plan did not refer to the ulcer either. The management plan referred to two-hourly turns and an air mattress. The person's multi-disciplinary notes from July 2017 indicated the area was not healing well and to implement hourly turns. The re-positioning charts showed staff were supporting people change their position as required on an hourly basis.

One person said, "I have no complaints. They are very kind." None of the people we spoke with could recall having had a need to raise a complaint and any minor issues had been quickly resolved. One person stressed, "It is just lovely here," and another told us, "I can speak up for myself and if anything wasn't right I'd soon tell them but at the moment I'm quite happy."

We looked at the complaints file and found a serious concern had been responded to appropriately, with a full investigation and disciplinary action being taken. The complainant was satisfied with the outcome.

Inadequate

# Is the service well-led?

## Our findings

One person said, "I am very happy here," and another told us, "I don't feel lonely." A further person said, "All the staff who work here are lovely." One relative said, "I think it's good here. People seem really happy and it's spotlessly clean everywhere. I visit every day more or less." The home had a friendly atmosphere and we observed many positive interactions between staff and people living in the home.

There was a registered manager in post who had been registered with the Care Quality Commission since April 2017 and we spoke with them on both days of the inspection. People told us that the registered manager was usually visible and approachable. One relative said, "We've no problems with the manager. They are approachable. I think their heart is in the right place." Another relative told us, "They're easy to talk to. I find [name] absolutely fine." One staff member's supervision notes stated, "I feel the new manager is very approachable."

We asked staff what they might improve about the home. One care worker said, "More staff and the right ones as staff morale is low and they moan a lot. There should be more support for seniors as they support us really well." The registered and deputy managers did not offer directional leadership during our time in the home which would have been beneficial over lunchtime especially. During our interview with the registered manager they explained they completed daily walk-arounds the home to identify any issues but these were not recorded and we did not observe this.

One relative we spoke with could recall completing customer feedback recently. Family members told us that there were relative and residents meetings but nobody had attended them except for one person when the new manager had started. This was verified by the registered manager who explained relatives and visitors to the home were frequent and shared any issues at their visits. We saw minutes of the first meeting held in September 2016 where comments about the home were favourable.

One care worker told us, "I would recommend the home as a place to work as I love it. I would recommend it for my relative if certain staff are on – not because the staff are nasty, but some just moan a lot." Staff had the opportunity to raise any issues at regular staff meetings and we saw minutes from meetings held in April, May and July 2017. We saw staff had raised concerns about low staffing levels in relation to dependency needs in April 2017 and the regional manager had agreed to a temporary increase for an interim period. There was also an encouragement for people to join in with wider community activities which they spoke to us about. The May 2017 meeting reinforced the importance of effective handovers between day and night staff. The July 2017 meeting reflected some of the initial measures the registered manager was to implement following our discussions on the first day of the inspection such as charts for thickening agents and reporting faulty equipment.

We asked the registered manager what support they received as they were a new manager. The registered manager said they found other managers in the provider's care home group supportive. They also said, "The regional manager visits on a monthly basis to provide supervision and they also do their own provider visits looking at all parts of the home. I am always able to ring them if I need them." We saw evidence of the

regional manager provider visits and these had provided an action plan to be implemented. However, not all of these had been followed as we found during the inspection and other areas which had been considered were not assessed in depth which meant limited oversight of the problems we encountered. The registered manager also explained an external auditor visited to conduct yearly 'inspections'. The report from June 2017 had highlighted some issues which mirrored our inspection findings but there was no evidence of action having been taken.

The home had their previous ratings and report on display in the reception area.

The registered provider had a quality assurance system in place. However, we found although numerous audits were completed by the registered manager there was limited evidence they were acted upon or filled in correctly. Monthly audits included staff files, care plans, health and safety, infection control, accident analysis, bed rails and other equipment.

There was also a medication audit. We looked at those completed for May and June 2017 and saw questions answered as being acceptable, did not correspond with our findings. Where issues had been identified such as dates of opening not being recorded, we saw this had been requested in May and deemed resolved in June. This did not match with what we found. Other issues we saw agreed as acceptable included the temperature of the medication room and the storage of medication which we also found to be an issue. The recording that the medication round had been conducted uninterrupted, which was not what we observed on either day of the inspection. The stock check counts at the end of the audit did not provide sufficient evidence to indicate whether any issues were noted, which meant the value of the information was limited. Neither audit had been scrutinised by the registered manager which meant they were not aware of any issues and no action plan had been created for the few areas where concerns were noted.

The monthly sling audit provided limited information as it did not indicate which belonged to who and what checks staff were to make regarding the condition of the slings. One person we observed using a stand aid was not 'allocated' a sling size so again staff did not have the guidance as to which one to use. While pressure sore audits provided a brief outline of a person's condition and what action had been taken to alleviate this such as specialist equipment and community nursing input, many of them had been acquired in the home and we saw no measures to try and reduce the likelihood of these.

People's weights were noted on a monthly basis with analysis as to whether they had lost weight. However, as previously stated, there were issues in the home with people nutritionally at risk so it was not evident risks were well managed. The bed rails audit in May 2017 had omitted to check one person who had had bed rails installed on 28 April 2017 which meant this check was not complete or robust enough.

The registered manager, who was open to feedback, had not ensured enough practices in the home were safe and measures that did exist to provide information to support such issues was not followed up or monitored effectively. This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 good governance as the monitoring of quality was not sufficient or effective enough to minimise the risk to people.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>There was a lack of mental capacity assessments in place for people unable to make specific decisions.<br><br>DoLS conditions were not being adhered to. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs<br><br>Not all people were being supported appropriately with their nutritional and hydration needs. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA RA Regulations 2014 Premises and equipment<br><br>Equipment being used to keep people safe was not being properly maintained. The home did not have a working hoist on the first day of the inspection. |

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 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Staff did not show competent moving and handling skills.<br>The assessments of risks did not include measures to reduce the likelihood of harm.<br>Medicines were not managed safely. |

**The enforcement action we took:**

Warning notice

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The monitoring of quality information was not sufficient or effective enough to minimise the risk to people. |

**The enforcement action we took:**

Warning notice

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>There were not sufficient numbers of staff to meet people's needs promptly and staff were clearly under pressure. |

**The enforcement action we took:**

Warning notice