Prime Life Limited

Westerlands Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was unannounced and took place on the 10 and 11 December 2015.

The last inspection took place on 7 April 2015. At that inspection we asked the registered provider to take action to make improvements to Regulation 17: Good Governance. After the comprehensive inspection on 7 April 2015 the registered provider wrote to us to say what they would do to meet the legal requirement in relation to the breach of regulation.

This inspection found that the registered provider had made sufficient improvements to indicate that the level of impact on people who used the service was reduced from moderate to minor impact, but there remained a breach of Regulation 17.

Westerlands Care Centre comprises of two buildings: Elloughton House and Brough Lodge. Brough Lodge is split into three units: The Garden Suite, Humber Suite and The Ridings Suite. Together the two buildings provide a total of 62 places to older people requiring nursing or personal care. Some people may have memory impairment and one unit in Brough Lodge cares particularly for people with significant anxiety problems. All rooms are single with en-suite facilities: toilet and a shower. There is a large accessible garden with a decking area, patio furniture and space to walk. There is ample car park space available at the side of the property.

The registered provider is required to have a registered manager in post and there was a registered manager at this service. 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.

During our inspection we found that the recording and administration of medicines was not being managed appropriately in the service. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

We had a number of concerns about the skills and knowledge of the staff on duty. We saw examples of extremely thoughtful, well executed personal care. However, we also saw interactions with people that appeared ill considered and unskilled. We found there was a general lack of understanding in how to manage people with significant anxiety problems. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

During our inspection we found that although people had access to sufficient meals and drinks, people said there was a lack of quality and choice of foods. The dining experience and how people were supported with their nutrition and hydration needs was not always appropriate and people's nutritional and hydration needs were poorly monitored. This was a breach of Regulation 14 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014 (Part 3).

People were not consistently treated the way they wanted to be treated. We observed some good interactions between staff and people living in the service. However, we also saw some evidence of poor care practices. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

We found that people who used the service had little or no input to the development of their care plans and we found that people's care plans did not always clearly describe their needs. We saw evidence that some people were not receiving the care they required, and noted that when appropriate care had been given this information was not well recorded. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

We saw that the registered provider had a policy and procedure for complaints and people/relatives were aware of it. However, those people who spoke with us said they lacked confidence that their complaints were listened to or acted on appropriately and there was evidence that people were not using this process. We have made a recommendation about the management of complaints.

We saw that the registered provider had made some improvements to the service and there was work on-going in the service to continue with these changes. There remained a breach of regulation in quality assurance although sufficient improvements had taken place to move the impact rating from moderate to minor. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

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

People told us that they felt safe living at the home. We found that staff understood how to keep people safe from harm and staff had been employed following robust recruitment and selection processes. The registered provider had an induction and training programme in place and staff were receiving regular supervision.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

The recording and administration of medicines was not being managed appropriately in the service.

There were processes in place to help make sure the people who used the service were protected from the risk of abuse and the staff demonstrated a good understanding of safeguarding vulnerable adults' procedures.

Assessments were undertaken of risks to the people who used the service and the staff. Written plans were in place to manage these risks. There were sufficient staff on duty to meet people's needs.

Is the service effective?

Requires Improvement

The service was not effective.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. We found the service to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

The registered provider had an induction, training and supervision programme in place. However, staff management of people with significant anxiety problems required improvement.

People were given sufficient meals and drinks to meet their needs. However, the dining experience and how people were supported with their nutrition and hydration needs was not always appropriate and information about nutritional and hydration needs was not always monitored and reviewed appropriately.

Is the service caring?

Requires Improvement

The service was not caring.

From our observations on the different units we found that staff

were kind but failed to be proactive in their caring role. The care being given was not person centred and there was a lack of attention to detail.

People were not consistently treated the way they wanted to be treated. We observed some good interactions between staff and people living in the service. However, we also saw some evidence of poor care practices.

Staff did not always treat people who used the service with dignity, consideration and respect.

Is the service responsive?

Requires Improvement

The service was not responsive.

We found that people who used the service had little or no input to the development of their care plans and we found that people's care plans did not always clearly describe their needs. We saw evidence that some people were not receiving the care they required, and noted that when appropriate care had been given this information was not well recorded.

We saw that the registered provider had a policy and procedure for complaints and people/relatives were aware of it. However, those people who spoke with us said they lacked confidence that their complaints were listened to or acted on appropriately and there was evidence that people were not using this process.

Is the service well-led?

Requires Improvement

The service was not well-led.

There was a manager in post who was registered with the Care Quality Commission. Staff felt the home was well run and they were supported by the management team.

There was a quality assurance system in place. However, further work was needed to ensure this was a robust system which assessed, monitored and reviewed the quality of people's experience of the service and took action to ensure improvements to the service were identified and actioned as needed.

Westerlands Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered 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 was unannounced and took place on the 10 and 11 December 2015. The inspection team consisted of five adult social care inspectors, two specialist advisors and two experts-by-experience. A specialist advisor is someone who can provide expert advice to ensure that our judgements are informed by up to date and credible professional knowledge and experience. One specialist advisor had knowledge and experience relating to older people and mental health, and the second specialist advisor was a pharmacy inspector. 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 experts-by-experience who assisted with this inspection had knowledge and experience relating to older people and those living with dementia.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider. We also sought relevant information from the East Riding of Yorkshire Council (ERYC) safeguarding and commissioning teams who informed us that earlier in 2015 they had some concerns about the service, but recent visits had shown the service was improving. The registered provider submitted a provider information return (PIR) in March 2015. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with a director, the registered manager, the clinical nurse lead and the deputy manager. We also spoke with 15 members of staff and spoke in private with nine visitors and 14 people who used the service. We spent time in the office looking at records, which included the care records for eight people who used the service, the recruitment, induction, training and supervision records for four members of staff and records relating to the management of the service. We spent time observing the interaction between people, relatives and staff in the communal areas and during mealtimes. We used the Short Observational Framework for Inspection (SOFI) on one unit. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

We looked at the systems in place for medicines management. We assessed nine medication administration records (MARs) and looked at storage, handling and stock requirements. We found that appropriate arrangements for the safe handling of medicines were not always in place.

Medicines were stored securely and the keys were held by the senior carer or nurse on duty. Controlled drugs were regularly assessed and stocks were accurately recorded. Room and fridge temperatures were recorded daily.

Medicines were administered by either the nurse on duty or a medicines trained carer. We observed a nurse administering medicines during our visit. Medicines were administered safely and documentation directed carers to a person's preference for administration. The morning medicines trolley round was not administered in a timely manner and was completed at 11.10am. Two medicines still required administration after the main round as they could not be located in the trolley. The nurse found these in the store area and administered these.

The arrangements for ordering and disposal of medicines were discussed with staff. We were told that the clinical lead ordered medicines for all areas. One controlled drug was seen to be over stocked; the senior was aware of this and intended to liaise with the GP regarding prescriptions for this item. We observed that medications were disposed of in a timely manner.

The majority of MAR charts were printed by the community pharmacy. We were told that medicines stocks were carried forward at the end of every month but saw several examples where this had not been done properly and one where the carried forward values did not add up so we could not be sure if the medicine had been administered safely.

Some people who used the service were prescribed 'as required' medications for pain relief and laxatives. As required protocols had been developed and were kept with the MAR charts. One protocol did not correspond to the person's current treatment as the pain medicine had been reduced in dose but the protocol had not been amended. This put the person at risk as effective guidance to care staff was not in place.

One person had returned from hospital where two medicines had been withheld for a short period of time. Review of these changes had not taken place and care staff were not aware of who was responsible for following this up. This person had therefore had their medicine withheld for longer than necessary. One person regularly refused eye drops, but no record was in place to show this had been addressed and reviewed.

Transdermal Application Records (body maps) were used to help ensure pain patches were used safely by ensuring they were applied to different areas of the body. We observed that one person had their patch applied to the same skin areas more frequently than recommended. This increased their risk from this

medicine.

One person was prescribed an antibiotic to be administered four times daily. The amount supplied provided a five day course however only eight doses had been administered and the course had been continued past the five days without consultation with the GP. This meant the antibiotic could not be effective.

These findings evidenced a breach of Regulation 12 (1)(2)(g) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We asked people if they felt safe, if the staff assisting them had the right skills and if they felt the premises were safe and secure. The majority of people told us they felt safe and most appeared content. The relatives who spoke with us also said they felt their relative was safe and reasonably well cared for. One relative told us, "The staff are very nice, [Name] was very poorly when they came here, but they are improving and we are hoping to get them home." This was confirmed by their family member who used the service and said, "The staff look after me very well, I do feel safe but they won't let me walk without this (their walking frame), I think I can a bit." We did not observe anyone assisting them or encouraging them to be more mobile although they obviously wanted to be as they were trying to get back to their own home.

Some people living in the service were unsettled about the behaviours of people who used the service. One person who used the service said, "I've been here three years and I asked for the gate (child gate) on the door as other people living here kept coming in, especially one person. I know they can't help it but they come and take my things and unmake my bed. I feel safer with the gate on the doorway but they still come and rattle it a lot trying to get in, that does worry me. There are more people here who are living with dementia than when I first came here." We looked at this person's care file and found that risk assessments for use of the gate were in place and reviewed on a regular basis.

Our observations of the service showed that especially on Brough Lodge there was a lack direction in the care being delivered. We saw that the staff tended to react to people's behaviours, movements or requests for assistance rather than be proactive. This reactive practice was the same on the more dependent unit (The Ridings) on the second floor. For example, people were free to move around The Ridings where physically able. However, during the majority of the morning we saw a lack of engagement with people in any meaningful activity which allowed for low intensity confrontation between people as they randomly came into contact with each other. Two people who we were able to have a limited conversation with appeared ill at ease and reported being unhappy. Others, however, did appear to be in good spirits, with one singing Christmas carols at different intervals.

During our inspection we had to offer support to prevent harm coming to two people on The Ridings as we found no care staff in the vicinity of either person. One person was standing up in the lounge area and was in danger of falling and one person was found hanging out of their bed and in danger of falling onto the floor. Our checks of the staffing rotas showed that there were sufficient numbers of staff on duty, which indicated that the staff were not covering the unit appropriately or carrying out regular checks on those in their bedrooms. These concerns were discussed with the director and the registered manager during and at the end of our inspection. They spoke with the staff on duty and we found better deployment of the staff on the second day of our inspection.

We found evidence that the management team were aware of the issues raised above in that analysis of the audits completed by the registered manager highlighted some staff deployment concerns on Brough Lodge. The accident and incident audit completed by the registered manager in November 2015 showed that within the service in the last month there had been 20 falls, three accidents and 21 other incidents. Five

people were admitted to hospital. These seemed to be average numbers for the service based on previous audits. The audit highlighted risks to people on The Ridings in particular and the action plan documented that the staffing levels on the unit had been reviewed so the senior care staff had more time to support the staff.
Care files had risk assessments in place that recorded how identified risks should be managed by staff. These included falls, fragile skin, moving and handling and nutrition; the risk assessments had been updated on a regular basis to ensure that the information available to staff was correct. The risk assessments guided staff in how to respond to and minimise the risks. This helped to keep people safe but also ensured they were able to make choices about aspects of their lives.

The information we held about the service indicated that we had received 45 safeguarding notifications from the registered manager in the last year. Many of these were minor incidents where one person using the service had exhibited agitated behaviour towards another person using the service. Prior to our inspection we had contacted the ERYC safeguarding team for relevant information about the service. We were told the team had received appropriate alerts when needed from the service, there had been a number of concerns raised in the last year but there was evidence of improvement.

The registered provider had policies and procedures in place to guide staff in safeguarding of vulnerable adults from abuse (SOVA). The registered manager described the local authority safeguarding procedures. This consisted of a risk matrix tool, phone calls to the local safeguarding team for advice and alert forms to use when making referrals to the safeguarding team for a decision about investigation. There had been instances when the safeguarding risk matrix tool had been used, when alert forms had been completed and when the CQC had been notified. These were completed appropriately and in a timely way. This demonstrated to us that the registered manager took safeguarding incidents seriously and ensured they were fully acted upon to keep people safe.

We spoke with three staff about their understanding of SOVA. Staff were able to clearly describe how they would escalate concerns both internally through their organisation or externally should they identify possible abuse. Staff said they were confident their registered manager would take any allegations seriously and would investigate. The staff told us that they had completed SOVA training in the last year and this was confirmed by their training records. The training records we saw showed that all staff were up-to-date with safeguarding training.

We asked people who used the service and their visitors if they felt there were enough staff on duty; we received some mixed feedback about this. One person was positive about the staffing and said, "I always seem well attended to." However, another person was less positive and told us, "There's not enough staff, they're always busy, or so they say." Relatives commented, "There's not enough staff. It's unusual to see this many trotting about. Is it because you're here?" and "I have two major issues. One is that care staff are still having to wash pots, so there are not enough staff on the floor. Then there are incidents when there is no member of staff in the lounge for 20 minutes. I've seen people fall and have had to intervene myself."

Discussion with the staff indicated that they felt they were extremely busy at times but that they worked together well as a team to make sure people received the care and support they needed.

We looked at the rota sheets for the four weeks leading up to our inspection. These indicated which staff were on duty and in what capacity and the staff we met on the inspection matched those on the rota sheet. The rotas showed us there were sufficient staff on duty during the day and at night, with sufficient skill mix to meet people's assessed needs. The staff team consisted of nurses, care staff, ancillary workers, administrator and catering staff. We discussed the deployment of staff within the service with the registered

manager. We were told that action was being taken to ensure there was a nurse, shift leader or senior carer on each unit every shift and that a senior was also based on The Ridings over the 24 hour period. We saw that additional staff were on duty to cover the one to one care being given to people who needed this extra support and who had been funded for the extra care.

We spoke with the maintenance person and looked at documents relating to the servicing of equipment used in the home. These records showed us that service contract agreements were in place which meant equipment was regularly checked, serviced at appropriate intervals and repaired when required. The equipment serviced included the fire alarm and the nurse call bell, moving and handling equipment including hoists, portable electrical items, electrical systems, water systems and gas systems. Clear records were maintained of daily, weekly, monthly and annual checks carried out by the maintenance person for wheelchairs, hot and cold water outlets, fire doors and call points, emergency lights, window opening restrictors and bed rails. These environmental checks helped to ensure the safety of people who used the service.

We gave feedback to the registered manager during our inspection that we saw three bedroom doors wedged open during our walk around the building with people / staff using a wheelchair, walking frame and metal door stop as door wedges. This meant there was an increased risk of harm to the people using these bedrooms in the event of a fire as the doors would not close. The registered manager said she would send the maintenance person around the home immediately to remove any inappropriate wedges. We were shown a copy of the fire risk assessment for the service, which had recently been updated.

The registered provider's business continuity plan for emergency situations and major incidents such as flooding, fire or outbreak of an infectious disease identified the arrangements made to access other health or social care services or support in a time of crisis, which would ensure people were kept safe, warm and have their care, treatment and support needs met. This had been reviewed in the last 12 months.

Personal emergency evacuation plans (PEEP's) were in place but these did not have individual details for the people who would require assistance leaving the premises in the event of an emergency. For example, they did not include each person's mobility needs such as how many staff or what equipment would be needed to help them evacuate the service and they did not detail the person's capacity to understand what was happening if the fire alarm went off. Instead they reflected the generic information for staff with regard to evacuating the building, such as 'horizontal evacuation'. Discussion with the registered manager at the end of the inspection indicated that they would take action to update each individual PEEP as soon as possible. The director told us they would ask the local fire protection officer to give them advice on how best to complete these.

We looked at the recruitment files of four members of staff. Application forms were completed, references obtained and checks made with the disclosure and barring service (DBS). DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. Interviews were carried out and staff were provided with job descriptions and terms and conditions. This ensured they were aware of what was expected of them. The registered manager carried out regular checks with the Nursing and Midwifery Council to ensure that the nurses employed by the service had active registrations to practice.

We found the level of cleanliness in the service was satisfactory and there was evidence of a cleaning schedule being in place and carried out daily. However, there were some areas of the service that needed attention including the laundry area. These were of low risk to the people using the service and had a low

impact on their daily lives. We gave feedback to the registered manager that some of the chairs in the lounge and conservatory on Elloughton House were dirty and stained and we were told that these should be cleaned on a night time by the staff. The servery area in the conservatory was unclean with spilt milk and food debris across the work surface and a dirty waste bin. We also noted there were malodours in a couple of bedrooms. The laundry room had clean clothing hung up in the dirty area, which posed a potential risk of cross contamination and there was no liquid soap or paper hand towels for staff to wash and dry their hands with. The registered manager told us that these issues would be dealt with immediately.

Requires Improvement

Is the service effective?

Our findings

During the comparatively short period we spent observing Brough Lodge, it was quite apparent that the level and intensity of care required by a considerable proportion of people who used the service was very high. We saw examples of extremely thoughtful, well executed personal care. However, we also saw interactions with people that appeared ill considered and unskilled.

Our observations of this unit showed that there were displays of genuine affection and positive interaction between people who used the service and staff. However, we also witnessed episodes where the more junior care staff members' verbal manner towards people was both confrontational and infantilising. For example, on two occasions whilst assisting one person to eat the member of staff spoke to the person as though they were a child, which resulted in them becoming verbally aggressive. We also witnessed another person who was repetitive in their verbal statement becoming more distressed due to staff actions. We saw that during the morning the person was wheeled around the floor space of the unit in a wheelchair, with their feet not correctly supported on the foot rests. We saw that this exacerbated their distress, so they sought comfort from a constant supply of faces as they were moved around. Further to this, we were aware of a member of staff, either through embarrassment or frustration with this person's constant calls for help to be laughing in response. We did not think that these negative reactions were malicious, but concluded that these staff lacked the knowledge and skills required to work with this client group.

Our interpretation of events regarding this person was reinforced as, following lunch, a senior care assistant provided this person with very direct, quietly executed, one to one care in the form of hand massage and gentle conversation. The person's response was notable in that they became soothed and relaxed and their repetitive statements ceased. We looked at care records and found there to be multiple notes under headings of 'Things that might distress me' and 'When I'm distressed I may' and 'What supports me', but found no readily displayed formulation or plan that could be followed by staff to assist the person. We noted staff had made requests for GP advice regarding the person's behaviour in order for their medication to be reviewed. Following the medicine review the staff made a request for a referral by the GP to the Mental Health Team, but we could not determine from the person's notes if this had been followed through. The manager told us that this request was refused by the GP involved.

Our concerns for there being a general lack of understanding in how to manage people with significant anxiety problems by staff were highlighted in an entry in this person's care file which stated, "……7.30 (Name) started to walk about the lounge shouting and refusing to sit when staff asked." We found that the above statement indicated the person's behaviour was an inconvenience to staff rather than a cue for the staffing team to consider seeking a coordinated approach to supporting the person's need. This apparent un-coordinated and un-collaborative approach to managing people's behaviours was a theme running through the care provision on The Ridings.

From our observation of staff interactions with people and care records that we looked at we found staff practice to be fragmented, with evidence of un-coordinated care planning and poorly directed intervention. Documents were present in order to record multiple elements of a person's daily activity, behaviour, bodily

need and these were generally well maintained and kept up to date. However, we could not see how this data was then analysed in any meaningful way to then best direct care and work toward improving the person's experience.

We were informed by the staff that monthly evaluation did take place, but despite the coded behavioural charts demonstrating significant changes in a person's presentation, no changes in care were seen to be agreed in response. People's care records had entries made referring to the use of ABC charts (Antecedents, Behaviour, Consequences). These can be valuable tools to assist the development of strategies to manage behaviour, however, no ABC charting was present and on questioning a staff member, we were then brought some ABC documentation that had just been introduced to the Unit.

In one care file we looked in we found that the person had been identified by an external Speech and Language Therapist (SALT) assessment as being at potential risk of choking. The assessment which was dated September 2015 recorded that the person needed to be directly monitored when eating, with small quantities of food at a time made available. However, on evaluation in October 2015 the staff had documented the person was "Independent" in eating and drinking. In the evaluation for eating and drinking in November 2015, there was no reference made to eating needs at all. This meant this person was at risk of choking and staff were not monitoring or reviewing this appropriately.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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.

Records given to us showed that seven people who used the service had a DoLS in place around restricting their freedom of movement. These were kept under review and applications had been submitted where needed for 10 other people and the registered manager was awaiting the outcome from the authorised supervisory body. Documentation was completed appropriately by the registered manager who displayed a good understanding of their role and responsibility regarding MCA and DoLS. The care records we saw reflected a general understanding of the principles and requirements of the MCA and DoLS and staff who spoke with us demonstrated a general grasp of the concept of MCA and DoLS. One staff member told us "People have the right to make their own choices about everyday things. We would not make anyone do something they do not want to. People have the right to say no and we respect that."

The registered provider had an induction and training programme in place and staff were receiving regular supervision. We were given a copy of the staff training plan, which indicated that the registered provider ensured staff received core training and service specific training. Staff told us that part one of their induction took place over two days, where they shadowed another member of staff and then they completed part two

which was computerised online questions and answers. We were told that staff were supernumerary until they had completed part two of the induction. Staff talked about '60 second' training sheets, which included information on subjects such as dignity, dementia, care plans and management of behaviours. They also said they had a package of training which included food hygiene, pressure care, safeguarding of vulnerable adults from abuse and infection control. Senior care staff told us that restraint was not used within the service; they also said that they had completed training on 'breakaway' techniques which gave them confidence in managing people behaving anxiously in the presence of staff and others.

Staff commented that they did not carry out moving and handling tasks within the service until they had completed the appropriate training. There were some gaps in this training; for example, the training plan indicated that 20 out of 68 staff still required moving and handling training and 12 staff had not completed fire training. Discussion with the director and the registered manager indicated that training was a rolling programme of sessions and that all staff would have completed this training within the year.

Evidence in the four staff files we looked at indicated that staff were having supervision with their line manager at least every two to three months. From the notes of these meetings we saw that the subjects covered included staff performance, people's care, training and any issues of concern. Staff said they found the supervision meetings helpful and that they were given the opportunity to express their views and opinions of the service. Staff told us "We have supervision every six weeks. If they have any concerns or you do, it is discussed. We also have appraisals. We are well supported here and the registered manager is approachable."

We saw evidence that individuals had input from their GP's, CPN, Mental Health Team, SALT, district nurses, chiropodist, opticians and dentists. All visits or meetings were recorded in the person's care plan with the outcome for the person and any action taken (as required). However, people who spoke with us said there were sometimes delays in them being able to speak with health care professionals or obtaining the necessary items prescribed for them. One person said they had been waiting to see the doctor because they had a bad back. They told us, "I've been waiting weeks. They said someone was coming today but no-one's been so far. Still I suppose there is time yet (this was at 2.00pm)." A relative told us that the GP had twice prescribed medical stockings for their relative as they had swollen legs. They said despite asking several times in the last 10 weeks the stockings had not appeared and the management had not chased it up. These concerns were discussed with the registered manager who said, "The time delay in receipt of the medical stockings relates to a manufacturing concern outside of the control of the service; this was followed up on several occasions." The registered manager told us they would ensure each person had received the care and equipment they needed.

We asked the registered manager about best practice within the service looking at external awards, dementia work and research. The registered manager told us that best practice input came from the dementia care training given to staff. The service was also registered with the Research Ready Network. Improving the lives and health of older people living in care homes is a major UK government priority. The Enabling Research in Care Homes (ENRICH) initiative and Research Ready Care Home Network aim to help make this happen, and to improve the consistency of support for research outside the NHS. The network brings together care home staff, people using services and researchers to facilitate the design and delivery of research. This hopes to improve the quality of life, treatments and care for all people using services.

Observation of the dining room experience showed that people were not always offered a choice of meal, but staff were aware of people's preferences and people enjoyed the meals they ate. On the dining tables were large folders that contained all the menus for every day over a four week period. However, this meant that people living with dementia would have needed to know what week it was and also the day of the week

in order to find the day's menu. We saw there was a blackboard menu, but this was not completed until later in the morning. We saw that the menus in the folders indicated that there was a choice of two main meals each day and these were illustrated so people could see what these were. However, the menus did not say what alternative meals were available and did not show pictures of the alternative meals or the options for the sweet course.

We received a mixed response from people when we asked them about the quality of their meals. One person who used the service told us, "I can ask for something else but it is usually a sandwich, you can only eat so many sandwiches." Another person was in the dining room at 11:45am and said they had yet to have breakfast. They told us, "This place is going downhill. I asked for eggs for breakfast but they told me they didn't have any. I then asked for toast and was told they didn't have any white bread." Comments from other people were, It's quite good, I've never turned it away." "The food is very institutionalised, it's very bland" and "The food is good."

One relative told me their family member had a soft diet. They said "Sometimes their meal just comes as a 'splodge' in the middle of the plate and other times it has separate colours and tastes." They said "The staff rarely know exactly what it is." This was confirmed when a staff member brought the lunch in. We asked what it was and the member of staff was unsure but thought it might be chicken.

Each unit had at least one dining room, but most people ate either in their bedrooms or the lounge. People were given a beaker of water or juice at their side, but we did not see them being encouraged to drink. The meal itself looked and smelled appetising and was presented on ceramic crockery and the cold drinks were in proper glasses.

There were sufficient staff to ensure people received their meals in a timely fashion. A number of people were able to feed themselves. However, other people needed assistance. We found that in one unit the television was left on creating a loud noise, which people living with dementia may have found distracting and disturbing so causing them to lose interest in their meals. We also noted incidents of staff assisting people to eat, but talking over them to colleagues across the room. This was unacceptable and undermined people's respect and dignity.

This was a breach of Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

We found the décor of the Brough Lodge to be of a high standard as one might expect considering it having been completed only a few years ago. The flooring was clear and 'slip free'. However, we found that further work was needed to make this unit 'dementia friendly'. Signage was not particularly prominent, particularly indicating toilet areas, but all the rooms had individual door colours to make room identification easier for the cognitively impaired. The bedrooms were clean, but many lacked any sense of individualisation. Some had personal possessions inside such as photographs, but none we had access to held any personal pieces of furniture and all the rooms looked rather sterile and un-homely. The registered manager told us, "All the people using the service are encouraged to bring their own personal possessions to the service in order that their room be personalised to their own taste and life history." We acknowledge the fact that we only viewed a percentage of the rooms in the unit and not all.

The floor plan for The Ridings was linear - circular floor plans are recognised as being less distressing for ambulant people living with dementia as this reduces the number of locked 'dead ends' in corridors that can lead to a sense of being enclosed with reduced freedom. During our time on this unit we saw a number of people become frustrated and distressed by being faced with dead ends and locked doors. Information

we received from the ERYC commissioning team indicated that this had already been discussed with the registered provider who had told them that plans were in place to move the unit to a floor where people would have access to outdoor space. This would provide people with more opportunity to walk without restrictions. However, no timescale for this to take place had been given.

One person who used the service told us they had, "Been cold for days" and had asked for their radiator to be fixed but nothing happened. They said, "It is too cold when all you can do is sit here all day." The room was cool and when we checked, the radiator was cold although the thermostat was on its highest setting. We asked a member of care staff and they said "We are aware of it, they are trying to sort the heating, it affects all the building." In the afternoon we observed three people in the lounges with blankets on them. We asked the director and registered manager if there were any heating problems on Brough Lodge and we were told, "There were some complaints about four months ago. The heating engineers came out and reviewed the system." However, as we informed the director and registered manager there still seemed to be a problem with the temperature on this unit. They agreed to get the heating engineers out again.

During our inspection we found that in the dining room of Elloughton House ten of the twelve chairs we looked at were coming apart at the joints. The chairs were also badly stained and covered in food debris. We were told by the director that the maintenance person would sort these out immediately and make them safe, whilst in the long term the chairs would be replaced by the registered provider. We saw that other repairs in the building were needed, in that within three bedrooms we saw one room had a wardrobe door missing, another had the door of the bedside cabinet hanging off and a third had a chest of drawers with a drawer front that was broken. We noted that action had been taken by the maintenance person before the end of our inspection.

Westerlands does benefit from having a large, well maintained secure garden that was reported to be well used in warmer weather. We observed one person using the garden as a smoking area.

Requires Improvement

Is the service caring?

Our findings

Some aspects of the service were not always caring. People were not consistently treated the way they wanted to be treated. We observed some good interactions between staff and people living in the service. However, we also saw some evidence of poor care practices. This was echoed by the comments from people who used the service and relatives visiting the service.

One relative said, "I'm happy [Name] is looked after, some of the carers are better than others, some are downright lazy." They added "I really want to get [Name] home." People told us, "The staff are very good if they weren't I'd tell them", "Most are okay, occasionally you get an awkward one" and "Majority of the staff are good. They only do what they're told."

Another relative told us they had visited the service the week of our inspection and, "I came in to the lounge to see two carers sat eating yoghurts and chatting. Behind them one person had taken off their trousers and undergarments and was taking off their shirt and they just ignored them. When I asked if they were going to help the person, they glared at me and one said 'my friend has just come down from upstairs and we haven't seen each other in ages'. Another time I saw a member of staff try to raise this same person to standing by pulling on their arms whilst they still had their legs crossed. The basic training seems to be nil." We asked this person if they had made a formal complaint to the registered manager and they said they had not. We asked them to use the registered provider's complaint system so the registered manager could take appropriate action.

A third relative told us "I visit every day. [Name] gets infections easily and they don't encourage them to drink enough or keep them clean." The qualified staff we spoke with confirmed that the person spoken about by the relative above was being monitored for urine infections. We were told that staff hoped to get them out of bed in order to prevent pressure sores, but when we checked they had not been out of bed when their relative arrived at lunch time or by the time we left the unit at 15:30. Our observations showed they did have access to drinks in their room.

Other relatives who spoke with us also expressed concerns about the lack of bathing in the service. Our checks of the bathing records indicated that these were not always being completed by the staff. For example, one person's record indicated that they only had one shower in October 2015 and that in November they had five showers, one bath and assistance with washing on six other days. That left 18 days without anything recorded. We looked at another person's care file and saw that their personal hygiene chart recorded they had one shower, then for ten days they had been washed. We spoke to one member of staff about this and they told us the person had been showered that day. However, when we showed them the hygiene chart they apologised and said it had not been recorded properly.

We observed an incident where one person complained they felt unwell and wanted to go bed. The staff member spoke to them, but then walked away. Very soon after the person began to call out that they needed the toilet and as there were no staff present they urinated where they stood. We discussed this with the director and registered manager who went onto the unit to speak with the staff. We were informed the

delay in attending to this person's needs was due to the fact that staff had to bring the stand aid to the assistance of this person.

In the afternoon of our inspection staff from The Ridings unit took a number of people out to the local garden centre. This left only two staff on duty. We saw that one member of staff was giving care to a person in their bedroom and the other was in the lounge area. As we walked around the unit we found one person in bed who was about to slip from their bed to the floor. They had clearly manoeuvred their position over some time and we were left concerned that some people may spend considerable periods un-observed. One of the staff responded to our call for assistance, but this left four people in the lounge unattended and they soon became agitated and distressed.

At about 11.30am one person on Humber Court was shouting "Nurse" regularly and when we went to see them, they asked for a drink although their cup with juice in was on the table close to them. We mentioned this to one of the staff and we went back with the member of staff who assisted the person to drink. We noticed that there was a strong odour near the bed, but the care staff settled the person and left the room. We checked on this person regularly and it was 14:00 before two staff went into the room and gave personal care to the individual.

We spoke with two health care professionals during the inspection. We were told that they had found some of the staff unhelpful and that communication was not always good. However, both said they had noted that improvements to the service were taking place and the younger staff were especially keen to learn.

From our observations on the different units we found that staff were kind and caring but failed to be proactive in their caring role. The care being given was not person centred and there was a lack of attention to detail. For example, one person was seen left walking around one unit without slippers on despite these being available. Everyone we saw had a beaker of juice or a cup of tea, but we did not see staff encouraging them to drink.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

We observed how staff promoted people's privacy and dignity during the day by knocking on bedroom doors prior to entering, ensuring toilet and bathroom doors were closed when in use and holding discussions with people in private when required. However, we saw some evidence of poor practice as well with staff talking over people at lunch time and people being left waiting for the toilet until they were incontinent.

We saw that the registered manager had carried out a dignity and respect audit in October 2015, and no issues had been highlighted from this. However, the audit used was a tick box and did not focus on people's experiences in the service. We discussed this with the director and registered manager who told us that they planned to introduce a 'Sit and Seen' document in the next month, which was an observational tool to monitor practices taking place. We were shown a copy of the tool which was detailed and would give a more in-depth look at dignity and respect.

People who used the service were not using external advocates to support them in making their wishes and choices around care practice. Instead we found that the care records showed that families were providing this support to their relatives. Where people had a person acting as their Power of Attorney (POA) this was clearly recorded in their care file. A POA is a person appointed by the court or the office of the public guardian who has a legal right to make decisions within the scope of their authority (health and welfare

and/or finances).

Requires Improvement

Is the service responsive?

Our findings

The service was not responsive around some aspects of care. We found that people who used the service had little or no input to the development of their care plans and we found that people's care plans did not always clearly describe their needs. We saw evidence that some people were not receiving the care they required, and noted that when appropriate care had been given this information was not well recorded.

Discussion with the registered manager indicated that this had been recognised through their care plan audits and was the reason for the introduction of a new document called 'About me'. This would give staff very person centred information about each person using the service, including how to approach each person and manage their anxious behaviour. We were told these documents would be kept with the food/fluid charts in the offices on each unit; this would make them easily accessible to staff. The registered manager told us they planned to start the roll out of the document in December 2015 starting with people with complex needs first.

The care files we looked at showed that the initial assessment of each person was comprehensive, but the detail of valuable person centred information varied significantly. The care files we looked at included information about a person's previous lifestyle, including their hobbies and interests, the people who were important to them and their previous employment. None of the relatives we spoke with were able to tell us they were involved in developing their relative's care file. However, we saw that a number of files had been signed by relatives who had POA for people and care reviews with families and the funding authority were taking place.

Not everyone who spoke with us was aware they had a care file, although some people said there was a folder containing their information. No one could remember the last time they were involved in discussion about their recent care and support. One person said "There is folder which I know tells them all about me. I haven't seen it or signed it but they are fully supporting my needs."

We looked at a selection of care files and found that the care plans lacked detail. For example one person was assessed as being at high risk of falls, but their care plan lacked clarity about what action staff were to take. The care plan documented that "Staff are to support with mobility and minimize the risk of falls – but there were no guidelines on what this support would look like or how many staff were needed.

One care plan documented that "[Name] needs assistance to cut up food as necessary into manageable pieces and to assist with feeding as needed." This information was vague and not clear about the type of support this person required and when. We saw another file had an entry dated 3 October 2015 stating "…..the senior is to liaise with GP/CPN regarding these concerns and obtain appropriate medical support" - we could find no subsequent record of such action being taken.

We looked at three care files that contained a care plan for wound care being carried out by the qualified nursing staff. The information about the actual wounds was detailed and descriptive and staff had recorded each time the wound was redressed. However, in one file staff had not recorded if sutures had been

removed following one attempt on 4 December 2015 when the person had become too agitated for staff to continue. The second file notes indicated that a wound had become inflamed and the GP had prescribed antibiotics. The staff instructions on the 3 December 2015 were to elevate the limb and observe. However, no further entries had been made in the last seven days. We checked the daily notes and the professional notes but nothing had been recorded. We discussed this with the clinical lead nurse who went to speak with the nurses on duty. They found that the sutures had been removed and that the infection was now cleared, but there were no explanations as to why the nurses had not documented this. This meant any new nurse on duty or agency staff would find it difficult to know what care had been given and what care was required.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

Given the amount of detail recorded about people's needs, despite the inconsistencies already noted, we were disappointed to see opportunities overlooked to allow for personalised activity. For example, we were aware of one person who, it had been identified in their care file, greatly enjoyed assisting with domestic chores. However, following lunch a member of staff washed plates and cutlery, thus preventing this person engaging in a meaningful activity.

We heard music playing in corridors and the television on in communal areas, but found that people could not hear what was playing and therefore did not watch the programmes or listen to the music.

The registered provider did not employ an activities coordinator, instead we were told that staff carried out activities as and when they had the time. We saw no sign of activities taking place in the morning of our inspection, although at midday we noted some staff sat with people looking through books. Some people were included in the conversation around the books, but many others appeared to be excluded. A number of people were sat with their eyes closed or asleep.

One relative told us that they had seen some staff sitting with their family member and reading to them. This person was mainly confined to bed and had severe communication difficulties. Another relative said, "The activity calendar doesn't seem to be as effective as it would indicate. It's window dressing. There's been posters displayed for two weeks now but the fitness regime's not started."

We were told a member of the care staff did a keep fit activity on a Friday and another carer was responsible for arranging choir sessions with people who used the service, but none of the people or the visitors we spoke with were aware of this. Initially we were told that the Westerlands choir would be singing that day. Other relatives were told the same. When we asked the staff member who was responsible for the choir, they told us that they usually facilitated the choir at about 6.00pm.

We spoke with staff about how they supported people's religious and cultural needs. They told us that there were church services held 'in-house' every month that were essentially Church of England faith. We were informed that the Catholic Church sent in representatives on request from people using the service and that people would be assisted to attend local church services as wished.

From our observations of the units we saw that people took part in low key activities including walks around the garden with staff, watching television, listening to the radio and reading newspapers and magazines.

We discussed the lack of activities taking place with the registered manager and the director. We were told these did take place and that we had probably just not seen what had taken place that day. Checks of the care files and discussion with the registered manager indicated that the recording of activities taking place

within the service was poor and could be improved.

A copy of the registered provider's complaints policy and procedure was on display and most people who spoke with us knew how to raise a concern although we did not see any leaflets about this. Relatives who spoke with us were not happy about how the service handled their complaints. Relatives told us, "I'm happy to go to the registered manager if I have a complaint but it doesn't make any difference. I have spoken with them but they tried to change the subject all the time, they didn't want to listen." Relatives said, "You never see them walking around, just in the office" and "They (the staff) don't interact with the people they just sit and talk to each other."

We spoke with two relatives who told us about a wide range of concerns, but who had not used the complaints procedure and neither of the two health care professional visiting the service had spoken with the registered manager about any of their concerns. This evidence and the comments from relatives indicated a lack of confidence in the complaints process. We asked people to use the appropriate process and two people said they would speak with the registered manager, but also said they did not think it would make any difference.

We looked at a copy of the registered manager's complaints audit. It showed that in September 2015 there had been one complaint from a health care professional and one complaint in October 2015 from a member of staff. The audit showed that no complaints had been received in November 2015, but from the information we received during our inspection from relatives there were a number of issues causing people concern that were not being captured and dealt with.

The complaints file did not contain any information about the complaints identified in the audits, nor did it contain the registered manager's responses to the complainants. The audit action plan gave a brief outline of what action the registered manager had taken, for example, care plans had been updated and hourly checks were completed on one person who used the service. Discussion with the registered manager indicated that they would ensure detailed records were kept in the complaints file from now on.

We recommend that the registered provider seek advice and guidance from a reputable source, about the management of and learning from complaints.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection on 7 April 2015 we identified that people were being put at risk because care records were not complete or up to date, and other records relating to the management of the service were not always accurately maintained. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

At this inspection on 10 and 11 December 2015 we found that the registered provider had followed the action plan they had written following the 7 April 2015 inspection. We found a breach of regulation remained for Regulation17: Good Governance. However, sufficient improvements had taken place to move the impact rating from moderate to minor for this breach.

We found that there was a quality assurance system in place but it was not always effective. We found during our inspection that care files and medicines were being audited but we had concerns about both of these areas of practice, which made us question how effective the audits were. We noted issues with the management of people's behaviour, the dining experience of people using the service, the complaints system and person centred care.

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

The registered provider sent in a provider information return (PIR) in March 2015. Prior to this inspection we contacted health and social care professionals to gain their views about the service. They reported some signs of improvement had taken place within the service over the last year, but progress was on-going.

We asked for a variety of records and documents during our inspection. We found these were easily accessible and stored securely. Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The registered manager of the service had informed CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

There was a registered manager in post who was supported by a deputy manager and an office administrator. Everyone who spoke with us was able to tell us the name of the registered manager and the deputy manager. The staff we spoke with were positive about the management and support they received and told us they thought the service was well run and they were happy working there. Staff told us, "I feel well supported by senior staff – even the deputy manager will work on the floor and help out", "Things get done if you report things – I like working here" and "I feel well supported by the managers." None of the staff who spoke with us reported feeling harassed or bullied.

Staff said the registered manager organised regular staff meetings and the staff could talk to them about any issues. They told us they were listened to and that information discussed with the registered manager was kept confidential whenever possible. Staff had regular supervision meetings and annual appraisals with

the registered manager and line manager. These meetings were used to discuss staff's performance and training needs; they had also been used to give positive feedback to staff.

When asked about the management of the home and the registered manager relatives said, "They never used to come out of their room, but lately they have been more visible" and "They talk the talk but don't walk the walk here. The carers give 150% of their time but they're not supported. There are leadership issues and supervision issues. The senior carers are not effective enough." "There is a lack of direction from top to bottom." "I like the manager but they are too nice to be effective." One relative told us, "I thought with talking and being honest things would get better, but nothing changes." "You get a smile and agreements, but things stay the same."

Feedback from people who used the service, relatives and staff was obtained through the use of satisfaction questionnaires, meetings and one to one sessions. This information was usually analysed by the registered provider and where necessary action was taken to make changes or improvements to the service. We were given copies of the latest meeting minutes and quality assurance documents to read.

People and relatives who had responded to the questionnaires had rated the service as good in 2015 with comments including, "I am very pleased my relative is in Westerlands", "The care staff are lovely with the residents and deal with challenging behaviour well" and "[Name] is kept clean and dry. They eat well and staff are approachable and friendly." The difference between the written comments and the verbal comments we received showed that there were mixed views about the service with some very positive experiences and some negative ones. Discussion with the registered manager and the director indicated that they were working on promoting better communication with people and their relatives and had introduced an open door approach for anyone to come in and speak to the registered manager. There were also 'Manager surgeries' where appointments could be made to discuss any concerns or issues with the registered manager.

We saw no evidence of written visions and values for the service and staff were not sure when we asked them about the 'culture' of the service. From our observations we saw that the staff team had a few experienced care staff, but the majority were inexperienced, young and willing to learn. The care staff we saw tried to help each other out, but there was a lack of prioritisation. The management team had recognised this and work was in progress to improve the day-to-day staff supervision, guidance and training through the deployment of senior, experienced staff on each floor. However, the effects of this had yet to be embedded in staff practice. Evidence in the staff supervision files we looked at showed that poor care practices were challenged by the registered manager, monitored and reviewed.

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 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 9 HSCA RA Regulations 2014 Person-centred care The registered person had inadequate arrangements in place to ensure the care and treatment of service users was appropriate and met their needs. Service users and relevant people were not encouraged to be involved in their care and treatment and their rights to make or influence decisions were not always respected. People who used the service did not receive person centred care that was appropriate, met their needs and reflected their personal preferences, whatever they may be. Regulation 9

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 provider failed to protect people against the risks associated with the unsafe use and management of medicines by the inappropriate arrangements for ordering, recording and handling of medicines used for the purposes of the regulated activity. Regulation 12 (1) (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs

Diagnostic and screening procedures Treatment of disease, disorder or injury	The registered provider failed to meet people's nutritional and hydration needs through a lack of quality, choice, menus, the dining experience and how people were supported. Information about nutritional and hydration needs was poorly recorded. Regulation 14 (4) a - d

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance People were not protected against the risks of inappropriate or unsafe care and treatment because of ineffective operation of quality assurance systems to identify, assess and manage risks relating to the health, safety and welfare of people who used the service. Regulation 17