Prime Life Limited

Westerlands Nursing Home

Inspection report

Elloughton Road
Elloughton
Nr Brough
Humberside
HU15 1AP

Tel: 01482667223
Website: www.prime-life.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

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 needs that challenge the service. All rooms are single with en-suite facilities: toilet and a shower. There is a large accessible garden with decking area, patio furniture and space to walk. There is ample car park space available at the side of the property.

We carried out an unannounced inspection of this service on 21 and 22 March 2016. This was to check that the registered provider was now meeting legal requirements we had identified at inspections in April and December 2015.

There was a registered manager in post at the time of our 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.

Following our inspection in April 2015 the service was found to be in breach of regulations pertaining to good governance. At the comprehensive inspection of the service in December 2015 we found the registered provider had failed to achieve compliance with this regulation. During this inspection we found evidence to confirm the registered provider remained in breach. Effective systems were not in place to monitor assess and mitigate risks to people who used the service or ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the comprehensive inspection of the service in December 2015 the service was found to be in breach of regulations pertaining to providing person centred care. During this inspection we found evidence to confirm the registered provider remained in breach. Care plans were not appropriate and did not meet the needs of the people who used the service or contain accurate information.

At the comprehensive inspection of the service in December 2015 the service was found to be in breach of regulations pertaining to providing safe care and treatment. During this inspection we found evidence to confirm the registered provider remained in breach. People who used the service did not receive safe care and treatment and avoidable harm or the risk of harm was not prevented

At the comprehensive inspection of the service in December 2015 the service was found to be in breach of regulations pertaining to meeting people's nutritional and hydration needs. During this inspection we found evidence to confirm the registered provider remained in breach. People were not supported to have adequate nutrition and hydration to maintain good health and reduce the risks of malnutrition.

During this inspection we also found evidence to confirm the registered provider was in breach of regulations pertaining to treating people with dignity and respect. We found staff actions did not always ensure people received respect and were treated in a dignified way.

During this inspection we also found evidence to confirm the registered provider was in breach of regulations pertaining to consent. We found that instructions in people's care plans failed to ensure the principles of the Mental Capacity Act 2005 were followed and best interest decisions were not in place as required.

During this inspection we also found evidence to confirm the registered provider was in breach of regulations pertaining to safeguarding people from abuse and improper treatment. We found evidence that staff were using unauthorised physical interventions/restraint without the skills and knowledge to do so safely. We reported two pieces of evidence we found during the inspection to the local authority safeguarding team to investigate due to the nature and seriousness of the evidence.

During this inspection we also found evidence to confirm the registered provider was in breach of regulations pertaining to staffing. Staff were not provided with the skills and knowledge to carry out their roles effectively.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

We found multiple breaches of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

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 registered 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 registered 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. People were not protected from abuse and avoidable harm. Staff used physical interventions/restraint without relevant training. Appropriate decisions were not made regarding the use of physical interventions/restraint. Internal policies regarding the use of physical interventions and restraint were not followed.

People's care plans did not contain appropriate information to enable staff to support people to manage their behaviours that challenged the service and others.

People were not cared for in a clean and hygienic environment. Infection control practices were not followed and this increased the risk of infection or cross contamination.

People did receive their medicines as prescribed. Suitable arrangements were in place for the safe storage, administration and recording of medicines.

Is the service effective?

Inadequate

The service was not effective. Staff employed by the service did not have the skills, knowledge and abilities to deliver care in line with people's needs.

Consent was not in place to provide people with care, treatment and support. Decisions made on people's behalf were not made in a best interest forum as required and the principles of the Mental Capacity Act 2005 were not being followed.

Care provided to people, that they resisted, had not been agreed in a best interest forum and was unlawful.

People were not supported to eat and drink sufficiently to maintain their health and wellbeing.

People were supported by a range of healthcare professionals but the service failed to implement their advice and guidance appropriately.

Is the service caring?

Requires Improvement

The service was not always caring. People were not always treated with dignity and respect by staff.

Action was not always taken to meet people's needs in a caring way.

We witnessed some positive interactions between staff and the people they supported.

Is the service responsive?

Requires Improvement

The service was not always responsive. People did not always receive personalised care that met their individual needs.

People's needs were not planned for and the service was not responsive to their changing needs.

The registered provider had a complaints policy in place at the time of the inspection.

Is the service well-led?

Inadequate

The service was not well-led. The quality assurance systems in place were inadequate and not operated effectively; it was not used to drive improvement within the service.

People did not receive high quality care in line with best practice.

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 was 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 ensure improvements had been made since our comprehensive inspection in September 2015.

This inspection took place on 21 and 22 March 2016; it was unannounced. On the first day of the inspection the inspection team consisted of four adult social care inspectors, an inspection manager and a specialist professional advisor. On the second day of the inspection the inspection team consisted of two adult social care inspectors, an inspection manager and a specialist professional advisor.

Before the inspection we spoke with the local authority safeguarding and commissioning teams to gain their views of the service. We were informed that a number of investigations were currently taking place regarding incidents that had occurred within the service.

We reviewed all of the information we held about the service, including notifications, inspection reports and the action plan sent to us by the registered provider which outlined the action they would take regarding the breaches we had identified at the December 2015 inspection.

During the inspection we spoke with 10 people who used the service and two visiting relatives. We also spoke with 13 members of staff including senior care staff, the assistant manager, nursing staff, a regional director and the registered manager.

We used the Short Observational Framework Tool for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed staff interacting with people who used the service and the level of support provided to people throughout the day.

We looked at 13 people's care records, including their initial assessments, care plans, reviews, risk assessments and Medication Administration Records (MARs). We looked at how the service used the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) to ensure that when people were assessed

as lacking capacity to make informed decisions themselves or when they were deprived of their liberty, actions were taken in their best interest.

We also looked at a selection of documentation pertaining to the management and running of the service. This included quality assurance information, audits, stakeholder surveys, recruitment information for six members of staff, staff training records, policies and procedures and records of maintenance carried out on equipment. We also completed a tour of the entire premises to check general maintenance as well as the cleanliness and infection prevention and control practices.

Inadequate

Is the service safe?

Our findings

People told us they felt safe, one person said, "Yes I feel safe – you're well looked after. They see something before it happens." A relative told us, "I think [Name] is safe here, I know they would ring me if there were problems."

People who used the service told us they did not have to wait for care and support and they felt staffing levels were adequate. One person said, "There is mostly enough staff, there are odd times, like at mealtimes when they are a bit short, but usually they are very good and have time for you." A second person said, "There seems to be ample staff." A third person commented, "I think staffing varies, that's the main worry, sometimes I feel that they need more help." However, they went on to say, "They work with you, which is what you want. I've had no dissatisfaction. There's always someone to call to help you." A relative told us, "I think things are improving, occasionally they are short of staff, but I don't think it's too bad."

During discussions staff were knowledgeable about the different types of abuse that may occur and what signs could indicate someone was suffering from abuse. One member of staff said, "If people are quiet out of their normal self, off their food, not wanting to mix with others or a change of behaviour around certain people – I would pass the concerns onto the manager or if necessary head office." A second person told us, "Bruising, acting differently, scared of people. If I did have concerns I would report it straight away." However, the staff failed to recognise that using physical interventions on people without completing training to enable them to do so safely put people at risk and could be seen as physical abuse.

People who used the service were not always protected from abuse and avoidable harm. We looked at the daily records for a number of people who used the service and found evidence that staff had used physical interventions to restrain people. On two occasions after staff had recorded that they had used physical interventions to restrain people, we saw subsequent reports which documented bruising which was consistent with the use of restraint.

In February 2016 staff recorded in an incident report that one person who used the service was displaying behaviours that challenged the service and others. The report stated, 'staff intervened, restrained them by holding their forearms and took them to her room.' The incident report stated three members of staff were involved in the episode of care and when we checked the registered provider's training matrix we found evidence to confirm only two members of staff had completed an advanced training course that provided them with the knowledge and skills to use physical interventions safely.

In March 2016 staff recorded in an incident report that another person who used the service was displaying behaviours that challenged the service and others. They were physically aggressive towards staff at 2.30 am, the time was significant because it suggested that staff could have moved away from the person and monitored them from a safe distance; they would not have had to protect other people who used the service. This was not the action staff taken as they recorded that physical interventions were used to stop the person hurting themselves and other people (staff).

The registered provider's challenging behaviour procedure stated, 'It is essential that there is a full and accurate recording of any incidents resulting in the use of restrictive physical intervention. Information about any antecedents, behaviours, consequences and approaches can be used during the review process to reduce frequency and intensity of future incidents' and 'The use of emergency restrictive physical intervention may be required occasionally to prevent harm or injury to the client themselves or others when behaviour is exhibited that has not been foreseen by a risk assessment. Evidence shows that injuries to staff and clients are more likely to occur during unplanned interventions therefore great care should be taken to avoid these situations. When used staff must be confident that the possible adverse outcomes e.g. distress/injury will be less severe than the adverse consequences associated with the intervention.'

Appropriate guidance had not been referred to and followed regarding the use of physical interventions [The Department of Health's 2014 guidance Positive and Proactive Care: reducing the need for restrictive interventions]. There was no evidence to support that there were further records made of the physical interventions used nor was there evidence that the incidents were investigated internally. Care plans were not developed or updated to reduce the possibility of any future reoccurrence or provide further guidance to staff regarding what action to take when either person displayed behaviours that challenged the service and others again. There was no review of staff actions to ascertain if they took acted appropriate of if lessons could be learned to prevent the use of physical interventions in the future; further training was not provided to staff so they could use physical interventions safely if it was required.

The mental health care plan (revised 29 September 2015) for the person who was restrained in February 2016 stated, '[Name] can be physically aggressive; [name] will choose vulnerable residents they will target when not being observed.' The 'action and strategies' section stated, 'Staff are to monitor [name's] whereabouts to reduce the risks of agitation and aggression' and 'staff are to encourage distraction techniques when [name] is agitated.' The care plan was not updated after the incident in February 2016 to ensure staff were provided with accurate information and guidance to meet the person's needs. The strategies of 'monitoring whereabouts 'and 'using distraction techniques' was not adequate because from 6 December 2015 to 27 February 2016 the person was involved in six incidents with other people who used the service, on each occasion the person hit or injured another person who used the service. This meant people who used the service were not protected from the risk of abuse because appropriate action was not taken to enable staff to manage people's behaviours that challenged the service and others.

After the incident which occurred in March 2016 a mental health care plan and an associated risk management plan was created which stated, 'Staff to observe for trigger factors' and 'use diversion techniques.' The care plan did not provide appropriate information regarding how the person should be supported and failed to specify what diversion techniques were known to be successful to re-direct the person. Failing to provide pertinent instructions could lead to the person's trigger factors going un-noticed or staff using ineffective distraction techniques which could lead to incidents taking place that could have been avoided. The care plan did not meet the needs of the person and failed to include what actions staff should take if the person displayed behaviours that challenged the service and others.

A member of staff we spoke with told us, "With regards to [name's] personal care, one member of staff will hold their hands and the other helps with their personal care." They went on to confirm that they would hold the wrist and back of the arm of the person to enable a second member of staff to provide personal care. Another member of staff said, "We use a hand hold on [name] during personal care and also for [name]. We use hand holds on both of those individuals." A third member of staff commented, "Sometimes we would come from behind and put our arms around them." They then demonstrated the technique which was a clearly a restraint hold. Using any form of physical intervention to provide care or support against someone's wishes is a form of restraint. The use of planned physical interventions restraint must be agreed

in a best interest forum so it is only used when a marked threshold has passed by trained staff providing care in the least restrictive way possible. When we checked the training records for the three staff who told us they used physical interventions they had not completed appropriate training to enable them to do so safely.

The above information demonstrated a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safeguarding service users from abuse and improper treatment. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

At our comprehensive inspection of the service in December 2015 we found people did not receive safe care and treatment. This was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People did not receive their medication as prescribed, appropriate action was not taken when people consistently refused their prescribed medication and medication protocols were not always accurate.

During this inspection we found that the service had taken action to improve the overall management of medicines within the service. However, we found further evidence that people still did not receive safe care and treatment which meant that the service continued to be in breach of this regulation; we are currently considering our regulatory response to this breach and will report on any action once it is completed.

Known risks were not managed effectively. For example, one person's toileting care plan stated they 'could become physically or verbally aggressive during pad changes…' The action and strategies sections stated, 'Staff to monitor for signs of agitation and to document this in [name's] notes/ABC chart and to manage this behaviour with one to one support.' Their personal hygiene care plan stated, '[name] will sometimes refuse all personal cares, this may lead to them having an aggressive outburst.' The action and strategies sections stated, 'When [name] refuses personal cares the staff are to leave them and return on an hourly basis.' We reviewed the daily notes for this person and saw that on 17 March 2016, '[name] has refused to sit on the toilet today but staff have managed to change their pad with three carers.' On 18 March 2016, 'regular pad changes regarding toileting, aggressive with four carers.' On 20 March 2016 '[name] was assisted by five members of staff to get showered they were very aggressive towards staff trying to hit out and kick.' The toileting and personal hygiene care plans lacked pertinent information and clear instructions regarding how to support the person when they displayed behaviours that challenged the service and others; this lack of information was a contributing factor in the inappropriate actions of staff.

One person with a known pressure sore had an adequate care plan in place. The care plan required the person to be repositioned every two hours. The associated risk assessment for the care plan stated the 'risk of the hazard' occurring was high and the 'severity of the hazard' was high. The repositioning charts we saw provided evidence that the person was not repositioned appropriately between 1 and 19 March 2016. Frequently gaps of three hours were found. Failing to implement preventative care regimes can have a significantly detrimental effect on people's health and welfare.

The above information demonstrated a breach of Regulation 12 (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

On the first day of the inspection we witnessed poor infection control practices on the top floor of Brough Lodge. There was a distinct smell in one corridor and we witnessed a member of staff mopping the floor. There was a bag on the floor that contained faeces because a person who used the service had defecated in

the hallway hall. When the member of staff had mopped the area they picked the bag up and carried it to the adjacent bathroom and put the bag into a clinical waste bin which was stored there. The member of staff then proceeded to push the mop bucket down the hall and went into a service user's bedroom and was overheard asking the person who used the service if they could mop their en-suite. Using contaminated water to mop other areas of the service increased the risk of spreading infections throughout the service.

When we went into the bathroom we saw that dirty laundry was stored in an open topped bin, there was a soiled seat cushion on the floor and another bin with a rusted footplate which meant it could no longer been cleaned effectively. In other bathrooms we found a used blue laundry bag on floor, a second clinical waste bin with clean towels left on top and a bath hoist with flaking paint and rusted areas which would prevent effective cleaning.

Windowsills and walls were marked and scuffed in the dining room in Elloughton House; dining room chairs were heavily stained with food debris. The wall plaster was cracked which meant it could no longer be cleaned effectively. The fridge had debris in the door seal and the waste bin had spillage stains down it. Five of the dining chairs were coming apart at the joints and were removed from use during our inspection. A visiting relative told us, "Hygiene has got better (since last inspection); but sometimes I don't think they clean enough."

The above information demonstrated a breach of Regulation 12 (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

At the time of our inspection 51 people were living at the service, 15 people required nursing care. The people were supported by 16 staff including senior care staff and one nurse. There was a team of ancillary staff including domestic, kitchen and maintenance. Throughout the inspection staffing levels appeared to be appropriate, but we witnessed very few activities taking place. A member of staff we spoke with told us they felt staffing levels were not unsafe but commented, "Some days you can't do activities, they won't give us an activities coordinator." When we discussed the staffing levels on Brough Lodge with a member of staff they explained, "I think there should be six staff, when we drop down to four in an afternoon we haven't got the time (to support people safely and effectively). Five or six people need two carers, it's very busy when we drop to four" and "I would like more staff on the top floor [Brough Lodge], it is really hard up there."

We checked six staff files and saw that staff had been recruited safely in line with the registered provider's recruitment policy. Before prospective staff were offered a role within the service an interview took place, references were requested and a Disclosure and Barring Service (DBS) check was undertaken. A DBS check is completed during the staff recruitment stage to determine whether an individual has a criminal conviction which may prevent them from working with vulnerable people. This, as far as reasonably practicable helped to ensure people were supported by staff who had not been deemed unsuitable to work with vulnerable adults. We spoke with a recently recruited member of staff who confirmed they could not commence working within the service until satisfactory references and DBS check had been received.

At our comprehensive inspection of the service in December 2015 we found people did not receive safe care and treatment. This was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People did not receive their medication as prescribed, appropriate action was not taken when people consistently refused their prescribed medication and medication protocols were not always accurate.

During this inspection we found that the service had taken action to improve the overall management of

medicines within the service. People received their medicines as prescribed. Medication Administration Records (MARs) included a photograph of the person, their known allergies, consent information and people's preferences for administration. For example, one person's MAR stated, 'I like my medication to be brought to me and I am able to take these myself in a medication pot' another person's included, 'I like my medication to be brought to me and I need assistance and reassurance with this. I like to take my tablets with water or juice.' The MARs were colour coded to match the colours of the blister packs [blister packs are produced by the supplying pharmacy, people's medicines are put into individual sections of the blister packs and are marked with the day and time of day when each tablet or set of tablets should be taken] which reduced the possibility of administration errors taking place.

Medicines, including controlled drugs were ordered, stored or disposed of safely. Medicines were stored in locked trolleys in dedicated rooms. A medication fridge was used to store medicines at cooler temperatures as advised by the manufacturers. We saw that the temperature of the room and the fridge were recoded daily to ensure the medicines were not stored at temperatures that could have an adverse effect on their potency. Regular stock checks were undertaken and records were kept of refused and destroyed medicines. Internal auditing had been introduced to improve the consistency of medicines management across the service.

Inadequate

Is the service effective?

Our findings

When we asked people if they believed the staff who supported them had the knowledge and skills to meet their needs we received mixed responses. One person said, "The staff are very good, they can't do enough for you, very obliging." Another person told us, "The staff are very good; they have been very patient with me." We were also told, "Some are better than others, some are quite exacerbating whatever you ask for is too much."

People who used the service told us they enjoyed the food that was provided. One person said, "The food is quite good, it doesn't suit everybody, but it's quite good", "They would sometimes give you an alternative. I get enough to eat, you can always ask for snacks." Other people said, "I don't know what we are having today but it's always nice" and "I think the food is very good. I haven't a clue what we are having today. They've always managed to supply me with something I like."

Staff did not have the skills, knowledge and experience to meet people's assessed needs because they had not completed relevant training. The registered provider deemed control of substances hazardous to health (COSHH), fire safety, infection control, moving and handling and safeguarding adults as statutory topics. From the 88 staff employed by the service, which included bank staff, only 34% had completed COSSH training, only 77% had completed fire safety training, only 50% had completed food safety, only 70% had completed moving and handling training and only 77% fire safety training.

The registered provider deemed dementia, emergency first aid, health and safety awareness and pressure care to be 'service specific' training for Westerlands Nursing home. From the 88 staff employed by the service, which included bank staff, only 65% had completed dementia training, only 58% had completed emergency first aid training, only 28% had completed health and safety awareness training and only 31% had completed pressure care training.

The service was registered to provide care and support to people who were living with dementia and supported some people who had complex needs and displayed behaviours that challenged the service and others. However, only 44% of staff had completed Mental Capacity Act and Deprivation of Liberties Safeguards training, only 40% of staff had completed challenging behaviour training and less than half of those staff had completed an advanced course which would provide them with the skills and knowledge to use physical interventions safely.

On the first day of the inspection we witnessed poor infection control practices which increased the risk of spreading health care related infections throughout the service. The actions of the staff member showed a lack of understanding of adequate infection prevention and control practices so the inspector had to intervene.

When we reviewed the incident reports completed by the staff we found that staff had used physical interventions/restraint on people who used the service when they had not completed the relevant training to enable them to do so safely. As the registered provider's challenging behaviour procedure stated,

'without adequate training staff cannot make appropriate decisions and be confident that the possible adverse outcomes e.g. distress/injury will be less severe than the adverse consequences.' When we reviewed people's care plans we found on numerous occasions staff were directed to provide support in people's best interests. Again without relevant training to understand the principles of the Mental Capacity Act 2005 staff would not have the skills and knowledge to understand that emergency care can be provided in someone's best interest (when there is no time for a best interest decision to be made in a best interest forum). At other times a best interest decision needs to be in place otherwise there is no consent to provide care and support that someone resists.

The above information demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, staffing. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

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. It sets out who can take decisions, in which situations, and how they should go about this. We found evidence to confirm that DoLS applications had been made on behalf of a number of people who used the service and had been accepted by the relevant authority.

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).

However, we found the service had not worked within the principles of the MCA and people were not provided with care that was the least restrictive. Some people's care plans informed staff to provide care and support in people's best interest without a best interest decision in place. For example, a person's personal hygiene and dressing care plan which was updated on 8 March 2016 stated, '[name] will refuse cares at times but staff have to be aware that they must act in [name's] best interest. [Name] may become aggressive during personal care.' The person's toileting care plan which was initiated on 30 January 2016) stated, '[name] is incontinent of urine and faeces throughout the day'. This meant the service was aware of the person's continence issues and that they refused personal care. Providing instruction to work in a person's best interests when there was no form of consent in place, from the person or via a best interest decision is inappropriate and a breach of the person's rights under the MCA.

Another person's toileting care plan which was updated on 23 September 2015 and personal hygiene care plan which was initiated 26 March 2015 stated the person would refuse support and may become aggressive. Neither plan included relevant information regarding what action to take when they continually refused support from staff. Their 'refusing personal care' risk management plan stated 'staff to ensure they are working in [name's] best interests'. On 20 March 2016 five members of staff showered the person whilst they were clearly indicating it was against their wishes. There was no best interest decision in place that enabled staff to provide care or support to the person against their wishes and there was no evidence that an appropriately skilled and experienced person had concluded that five members of staff showering the person was in their best interest. There was no evidence to support that care was provided in the least restrictive way. Any form of planned and on-going support that people received against their wishes failed to follow the principles of the MCA.

The above information demonstrated a breach of Regulation 11 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014, need for consent. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

At our comprehensive inspection of the service in December 2015 we found that the service had failed to provide person centred care and treatment. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that the service had failed to make satisfactory improvements in relation to the requirements of Regulation 9 described above. This meant that the service continued to be in breach of this regulation; we are currently considering our regulatory response to this breach and will report on any action once it is completed.

At our comprehensive inspection we found 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 always recorded.

During this inspection we found that people's individual care plans contained contradictory information that increased the risk of aggravating their known health problems, care plans were not updated to reflect people's current levels of needs after incidents or internal assessments and some people's care plans lacked insight in to the person, which would have prohibited person centred care being delivered.

A person's mental health care plan which was initiated on 19 January 2016 stated, '[name] can get verbally aggressive but has no history of physical aggression.' The daily reports for the person indicated that they were physically aggressive towards staff on 19, 27, 29, 30 January 2016 and 14 February 2016. The care plan was not updated as required to incorporate triggers to the person's behaviours or examples of distraction techniques that staff could use to successfully engage the person.

A person's mental health care plan) stated, '[name] has vascular dementia and this had led to a change in their personality. [Name] can be physically and verbally aggressive at times and will throw objects, threaten people and use offensive language'; '[Name] has depression which leads to low mood. This can trigger their behaviours.' The care plan included no guidance for staff to follow regarding how to manage the person's behaviours. The associated risk management plan for the person's 'aggressive behaviour' stated, 'Staff to observe for trigger factors' and 'use diversion techniques' but failed to inform staff what the person's trigger factors were or what diversion techniques were known to have been successful to distract the person. Using generic terminology and failing to include pertinent information can lead to people's actual trigger factors being missed and opportunities to re-direct people which can lead to them displaying behaviours that challenge the service and others.

The above information demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, person centred care and treatment. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

At our comprehensive inspection of the service in December 2015 we found that the service had failed meet people's nutritional and hydration needs. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that the service had failed to make satisfactory improvements in relation to the requirements of Regulation 14 described above. This meant that the service continued to be in breach of this regulation; we are currently considering our regulatory response to this breach and will report on any

action once it is completed.

At our comprehensive inspection it was apparent people were not always offered a choice of meal. Large folders were on a number of dining tables which 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 day and what week it was in order to know what options were available. Although people had access to sufficient meals and drinks, people said there was a lack of quality and choice of foods. We found people's nutritional and hydration needs were poorly monitored.

During this inspection we found that when concerns with people's nutritional and hydration intake were highlighted, appropriate action was not always taken to support people effectively. One person's eating and drinking care plan was initiated on 19 January 2016 and rated the 'risk of the hazard occurring' as low and the 'severity of the hazard' as low. There was a hand written update on 1 February 2016 that stated, '[name] refuses to eat and drink' and 'fluid to be pushed constantly.' The risk rating was not updated to reflect the severity of this person's needs. A malnutrition universal screening tool was completed for the person on 25 January 2016 and 17 February 2016. On both occasions the person was rated as being at high risk of malnutrition. The eating and drinking care plan was not updated and the 'risk of the hazard occurring' and the 'severity of the hazard' remained as low. A dietician advised the service on 10 February 2016 to 'prompt with high calorie drinks and snacks. To ensure all drinks were fortified and to offer milkshakes, ice cream, whole milk drinks, milky coffees and full fat yoghurts.' The eating and drinking care plan was still not updated.

The person was not offered and encouraged to drink suitable amounts and the dietician's advice was not followed to an adequate level. No targets were created regarding the amount of fluid the person should be offered and their needs were not met.

Another person's eating and drinking care plan was initiated on 22 September 2015, it stated, 'Staff to report any weight loss to the dietician.' The person's 'must and weight record' recorded on 27 January 2016 showed their weight was 81.70kg which equated to low as a risk category. On 26 February 2016 their weight was 75.80kg which equated to high as a risk category. The care plan was not updated following their weight loss and the change in the risk score, there was no evidence that confirmed a dietician had been updated regarding this change.

Another person's eating and drinking care plan stated, 'Staff to encourage [name] to drink at least 1500ml per 24 hours.' It also stated, '[name] is to have all of their prescribed Fortisips daily, this too should be entered on the fluid chart' and 'Forticreme (once a day) in addition to Fortisip compact (three times per day).' From 1 to 7 March 2016 the person drank 1500mls in 24 hours on only one occasion. On five occasions they did not drink their prescribed Fortisips or eat their Forticreme. On five occasions the person was not offered 1500mls of fluid in a 24 hour period. The person was not supported effectively to drink adequate amounts and no targets were created regarding how much they would need to be offered to achieve the 1500mls the care plan stated they needed to drink.

The above information demonstrated a continued breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, meeting nutritional and hydration needs. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

The service had recently asked people who used the service to complete questionnaires regarding the different types of food they enjoyed and what they would like to see on a newly designed menu that was being developed. The questionnaires contained visual aids to help support people make their choices.

We saw evidence to confirm that a range of healthcare professionals were involved in the care and treatment of people who used the service including GP's, dieticians, community nurses, chiropodists and opticians. However, advice and guidance was not always implemented effectively as evidenced above.

Requires Improvement

Is the service caring?

Our findings

People who used the service told us the staff who supported them were caring. One person said, "The staff are very good, they can't do enough for you, very obliging." Another person said, "They are extremely good to me." A relative we spoke with said, "The staff are caring, more so as they get to know [Name]."

People who used the service were not always treated with dignity and respect. For example, one person had a large pressure sore on their shin. A photograph had been taken of the wound so that its progression or remission could be monitored. The picture had been taken from an angle that showed a lack of consideration for the person's dignity as their genitalia was visible in the picture.

We reviewed the additional support notes for one person who used the service and the daily reports for another person. We found staff had recorded inappropriate information and failed to take into account people's mental health conditions when reporting on their actions.

The additional support notes for one person recorded they displayed disinhibited behaviours and had removed their clothing on a number of occasions. No plans had been developed to meet the person's known needs which meant that the service had persistently missed opportunities to support the person to maintain their dignity.

On the first day of the inspection we witnessed a poor episode of care in Brough Lodge. A person's continence pad could be seen as it was not in place and they were lifting their skirt trying to adjust it. A member of staff intervened and offered to help the person in the bathroom, but the person refused. The member of staff was then observed trying to pull up the incontinence pad in the busy communal area with no regard for the person's dignity.

A person appeared to be distressed and was repetitively calling out; requesting to go outside. The person required the use of a wheelchair and we witnessed a member of staff taking them out into the garden. The member of staff provided no verbal reassurance to the person who continued to call out and held a conversation with another member of staff as they took the person outside. The episode of care was not carried out in a caring way and showed a lack of respect for the person who used the service.

The above information demonstrated a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, dignity and respect. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

At our comprehensive inspection of the service in December 2015 we found that the service had failed to provide person centred care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that the service had failed to make satisfactory improvements in relation to the requirements of Regulation 9 described above. This meant that the service continued to be in breach of

this regulation; we are currently considering our regulatory response to this breach and will report on any action we take once it is completed.

Staff were not always aware of the preferences of the people they were supporting. For example one person's communication plan which was updated on 3 March 2016 stated, 'Staff to spend time with [name] to establish their likes and dislikes.' The person had lived at the service May 2015; their likes and dislikes should already have been known and recorded to enable staff to engage with the person in a meaningful way.

A person told us they got up around 7:30am with the staff coming in to assist them. The person said "It is a bit early; I would prefer to get up around 9:00am." When we asked if they had any choice about the time of getting up they said "No, I don't think so. The staff come in and I get up when they say." The person went on to say they went to bed at around 8:30pm and again this was because staff came to take them to bed and not through their personal choice.

The above information contributed to the continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, person centred care. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

People were not always supported to maintain their independence. We saw an entry in one person's daily report which stated, '[name] becomes verbal and aggressive at times towards other residents and staff. Carer trying to assist [name] to toilet, she shouted I don't need your help I can do it myself when actually they can't manage on their own making a lot of mess in the toilet and dropping faeces all over the toilet floor.' People must be enabled to maintain their daily living skills and independence. There should be recognition within the service that people will be able to complete a task one day, but may require more assistance on other days; their attempts to remain independent should not be discouraged or criticised.

Staff failed to work proactively to meet people's needs in a caring way. For example a person's mental health care plan stated, '[name] has vascular dementia and this had led to a change in their personality. [Name] can be physically and verbally aggressive at times and will throw objects, threaten people and use offensive language'; '[name] has depression which leads to low mood. This can trigger their behaviours. [Name] will attempt to hit others and scratch them at times' and '[name] behaviours are more prominent just before tea when they become agitated.' The care plan included no guidance regarding how staff could manage these behaviours such as taking the person out before tea to reduce their agitation. The person's pre-admission assessment recorded that the person, 'loves going out' and could help to reduce the person's anxiety before they displayed behaviours that challenged the service and others.

We saw that another person had flowers and cards in their bedroom and they told us that they had celebrated their birthday a couple of days before our inspection. We asked if they had a special cake or meal for their birthday but the person said no.

We saw in the daily reports for one person that they had been administered PRN (as required) medication to help reduce the anxieties and levels of agitation. The person had asked a member of staff if they could have a cigarette, but were told by the member of staff it was dark so they could not. The person became agitated and displayed behaviours that challenged the service so PRN medication was administered. If the staff member had supported the person to have a cigarette the incident could have been avoided and PRN medication would not have been required.

We also saw some positive interactions between the people who used the service and staff. We saw staff

sitting and talking to people and trying to engage them in activities in Elloughton House and overheard positive examples of person centred care and staff speaking with people in an appropriate tone and in a respectful way.

Requires Improvement

Is the service responsive?

Our findings

People who used the service told us they knew how to raise concerns or make a complaint. One person said, "I have no problems with staff; I would see the manager round the corner if I had any concerns." A relative told us, "I have been encouraged by the nurses to complain if needed." They went on to say they had raised concerns in the past and they had been addressed.

At our comprehensive inspection of the service in December 2015 we found that the service had failed to provide person centred care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that the service had failed to make satisfactory improvements in relation to the requirements of Regulation 9 described above. This meant that the service continued to be in breach of this regulation; we are currently considering our regulatory response to this breach and will report on any action once it is completed.

At our comprehensive inspection we found a lack of detail in people's care plans which could lead to people receiving inconsistent support that was not delivered in a person centred way. We also found that nursing staff failed to complete accurate records of the treatment they had provided to people.

During this inspection we found that people's care plans did not reflect their current care needs and lacked appropriate guidance to enable staff to support people effectively. People's care plans were not updated after specific incidents or advice and guidance from relevant professionals. This meant that the service was not responsive to people's needs which put people at risk of receiving inappropriate and ineffective care. For example, one person who used the service was not eating sufficiently; after speaking to a GP the service received guidance from a dietician. The advice included offering high calorie drinks, milk shakes and ice cream. The person's care plan was not updated to incorporate the information provided and subsequently staff failed to implement it.

Another person's pressure care, care plan rated the 'risk of the hazard occurring' and the 'severity of the hazard' as low. A tissue viability risk assessment was completed after the creation of the care plan recorded a score of 22 which indicated the person was at very high risk of developing tissue damage. A body map was completed on after the risk assessment that showed the person had pressure related wounds. Their pressure care, care plan was not updated to reflect the heightened risk and was not an accurate reflection of their needs. Failing to ensure care plans reflected known risks and provided accurate instruction to staff; increased the risk of the person developing pressure sores. The service was not responsive to the person's changing needs, which may be a contributing factor in the development of the pressure related wounds.

A person's mental health care plan stated that they had a history of verbal aggression, but had never displayed physically challenging behaviours. The daily reports for the person indicated that they were physically aggressive towards staff who tried to provide personal care on 19, 27, 29, 30 January 2016 and 14 February 2016. Their care plans were not updated as required. The service failed to respond to the person's

behaviours and develop plans of care to meet the person's needs regarding their personal care needs and behaviours that challenged the service and others.

Another person's eating and drinking care plan recorded staff were to report any weight loss to the dietician. On 27 January 2016 their weight was 81.70kg which equated to low as a risk category. On 26 February 2016 their weight was 75.80kg which equated to high as a risk category. The care plan was not updated following their weight loss and the change in the risk score, there was no evidence to show a dietician had been contacted for their advice and guidance as the care plan required. The service had not responded appropriately to the person losing nearly 10 per cent of their body weight in less than one month.

The above information demonstrated a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, person centred care. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

The registered provider's complaints policy and procedure were displayed within the service which included information regarding how to make a complaint, response times and what action people could take if they felt the response to their complaint was unsatisfactory.

At our comprehensive inspection of the service in December 2015, we discussed the lack of activities taking place with the registered manager and the regional director. We were told activities 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.

During this inspection we witnessed very few activities taking place and saw people spent the majority of their time in communal areas with televisions or radios on, but without meaningful engagement. Staff confirmed that the staffing levels within the service made it difficult to provide activities as they focused their time on carrying out care tasks. The service did not employ an activities co-ordinator and we saw little improvement had been made regarding people's social care needs since our comprehensive inspection.

Inadequate

Is the service well-led?

Our findings

When we asked people if they thought the service was well led we received mixed responses, some people were positive and their comments included, "I think it's great here, everything they do is for your benefit" and "Seems to be well-led." Other people told us they thought the service could improve in this area and some of their concerns were echoed by the staff we spoke with. For example one member of staff said, "Things do not always get dealt with straight away, so many different managers it seems to take longer for things to get done, it does get dealt with but it just takes longer."

At our comprehensive inspection of the service in December 2015 we found the service to be in breach of regulations pertaining to person centred care, safe care and treatment, meeting people's nutritional needs and developing and maintaining adequate governance systems (Regulations 9, 12, 14 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). After the inspection we received an action plan outlining how compliance would be achieved. Despite this, during this inspection we found that the service continued to be in breach of the regulations stated above and we found evidence to support further breaches in a further five regulations. In total the service was in breach of regulations 8, 9, 10, 11, 12, 13, 14, 17 and 18. The service was not well-led and processes had not been established to ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our comprehensive inspection of the service in December 2015 we found that the service had failed to operate good governance systems in the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service had been in breach of regulation 17 since April 2015 which spanned three inspections.

During this inspection we found that the service had failed to make satisfactory improvements in relation to the requirements of Regulation 17 described above. This meant that the service continued to be in breach of this regulation; we are currently considering our regulatory response to this breach and will report on any action once it is completed.

The quality assurance systems utilised by the service were inadequate. The governance systems used to ensure people's needs were accurately recorded and planned for were ineffective. They failed to ensure people's care plans reflected the most recent assessments of their needs, which increased the risk to the people who used the service. For example, one person had a mobility care plan in place that had been initiated on 19 January 2016, on 1 February 2016 a hand written update stated, '[name] no longer weight bearing, use of wheelchair needed for transporting.' A mobility assessment' was also completed on 1 February 2016 which stated the person required three staff for 'sitting/standing', three staff for 'toilet/bathing' and 'three/four' staff for 'transfers'. This new information was not used to update the person's care plan to ensure staff were aware of their current level of support needs. On 13 February 2016, an 'incident report' was completed which stated, '[name] was being assisted with personal cares prior to retiring. Two staff assisted them onto their feet in order to transfer them from their bed. Their legs buckled and they ended up on the floor...' As recorded in the 'mobility assessment' two members of staff were not adequate, the person needed three or four staff for transfers. The lack of accurate information in the

person's mobility care plan was a contributing factor to the person's fall and highlights the inadequacy of the care plan reviewing system.

The same person's personal emergency evacuation plan (PEEP) was also not updated following the mobility assessment. The PEEP stated, 'assistance to walk to safe area (wheelchair if needed) constant reassurance.' The failure to ensure accurate information was present in the emergency evacuation plan could lead to the person not being supported effectively in the event an emergency.

The governance systems used to mitigate, reduce or remove the risk to people who had developed pressure sores or were at risk of developing pressures sores were inadequate. People did not receive appropriate pressure relief and were not repositioned in line with their care plans and associated risk assessments. One person with a known pressure sore had an adequate care plan that required the person to be repositioned every two hours. The person had been assessed as being at high risk of the hazard occurring and the severity of the risk was also high. We found records that the person was not repositioned appropriately between 1 and 19 March 2016.

Another person's pressure care, care plan rated them as being at low risk of pressure sores occurring and stated the severity of the hazard was also low. However a tissue viability risk assessment was completed after the care plan had been produced which rated the person at very high risk of developing pressures. The person's care plan was not updated and a repositioning schedule was not introduced. This increased the risk to the person because appropriate action was not taken. The service's governance systems were not effective in ensuring action was taken to mitigate known risks to people's health.

Systems utilised by the service to ensure action was taken to improve the service after incidents and accidents occurred were ineffective. We reviewed the daily reports completed by staff and found evidence that staff had used physical interventions/restraint despite the registered manager and regional director informing us that restraint had not been used within the service. The registered manager told us, "I review all of the incidents and transfer them onto our system; I don't know about anyone being restrained."

The daily reports we looked at included statements such as, 'restrained them by holding their forearms and took them to their room', 'I then sat [name] down to keep them from hurting themselves or anyone else. They went for my face and drew blood in a scratch and knocked my glasses off. Whilst I was trying to restrain them…', 'Staff member [name] and staff member [name]; escorted [name] to their bedroom to calm down. They remained in their room for several minutes then returned to the lounge where they continued shouting and threatening staff. [Name] was again taken to their room' and '[Name] was assisted by five members of staff to get showered they were very aggressive towards staff trying to hit out and kick.' None of these incidents were investigated to ensure staff's actions were appropriate. The regional director or board of directors were not informed of the physical interventions used by untrained staff. People's care plans were not updated to ensure appropriate guidance was in place for staff and staff training was not carried out to ensure staff had the skills and knowledge to manage people's behaviours that challenged the service and others.

Systems utilised by the service failed to ensure the registered provider's policies; including the policies regarding the use of physical interventions and restraint were followed. The registered provider's challenging behaviour procedure stated that any use of physical interventions/restraint had to be fully recorded and acknowledged that physical interventions may be required in emergency situations but only by trained staff because the decision to use any kind of physical intervention/restraint may not outweigh the benefits of using it.

Without adequate training staff cannot make appropriate decisions and be confident that the possible adverse outcomes e.g. distress/injury will be less severe than the adverse consequences associated with the intervention. However records show staff had used physical interventions/restraint without completed relevant training to enable them to do safely. The registered provider's policies were not followed by the service.

The falls incidents and accidents audits were not used appropriately to mitigate potential or future risk and were not an accurate reflection of what occurred within the service. For example incidents occurred on 2, 7, 17 and 25 February 2016 that were not recorded in the falls incidents and accidents audit for February 2016. This could lead to incidents not being reviewed appropriately to ensure appropriate action was taken, medical attention was sought as required and people's care plans were updated to reflect their current level of need.

An incident occurred on 14 February 2016; the incident report stated a one inch blister was found on the person's chest. The falls incidents and accidents audit stated they had no injuries. Failing to record the actual injuries sustained by people could lead to them not receiving the care and treatment they require in a timely way.

An incident occurred on 19 February 2016; the incident report stated, 'During personal care [name] become more agitated. Whilst assisting [name] back into bed they became physically aggressive, as they laid down they lashed out hitting staff member [name] in the arm and mouth busting the inside of staff member [name's] mouth and gum. [Name] then continued to shout and lash out and would not settle. [Name] shouted and swore for about 30 minutes before settling.' The falls incidents and accidents audit recorded staff member [name] had been involved in an incident but failed to record the name of the person involved. This could lead to inaccurate figures being calculated and could mean people's care plans are not updated to reflect their needs and levels of behaviours.

An incident occurred on 1 February 2016 which involved two people who used the service. The incident form stated one person had accused another person of biting them and when staff looked at their arm there were two puncture wounds. The falls incidents and accidents audit did not record both people when a service user on service user incident occurred which could lead to altercations between two people not being picked up which could lead to lead further incidents taking place.

Effective systems were not in place to ensure compliance with the principles of the Mental Capacity Act 2005 (MCA) was followed. When we reviewed people's care plans we found on numerous occasions staff were directed to provide support in people's best interests. However, there was no indication of the decision that had been made regarding what was in the person's best interest. Only 53% of the staff had completed MCA training so they had not been provided with the skills and knowledge to understand that they can work in someone's best interest in an emergency situation but on-going support provided without consent cannot take place and is a breach of people's human rights.

Appropriate systems had not been implemented to ensure that staff were trained appropriately or had the skills and knowledge to meet the assessed needs of the people who used the service. Records showed staff were not trained in line with the registered provider's requirements. Staff recorded they used physical interventions without completing relevant training to enable to do so safely. Only 34% of staff had completed control of substances hazardous to health (COSHH) training even though a serious incident had occurred at another of the registered provider's services. We were told by the regional director that this incident had been used to improve the control of ingestible items across the registered provider's services. However, we found staff had not completed training and we found items such as COSSH and disposable

gloves were not locked away securely during our inspection.

The above information contributed to the continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

Staff were not always provided with a suitable forum to contribute to the development of the service. A member of staff told us, "No team meetings; management do general staff don't, but we work well as a team and deal with issues ourselves."