Ideal Carehomes (Number One) Limited

Hambleton Grange

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 16 and 17 May 2017 and was unannounced.

Hambleton Grange is a care home service without nursing. The service provides accommodation and residential care to a maximum of 50 older people and people living with dementia. On the dates of our inspection there were 49 people who used the service.

The service re-registered with the Care Quality Commission (CQC) in August 2015, due to a change of legal entity. This was the first inspection of the service since it re-registered.

The registered provider is required to have a registered manager in post. At the time of our inspection the service had been without a registered manager since April 2016. We have written to the registered provider about this, separately to this report. 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.

There was an interim manager who had been in post for 12 weeks who assisted us with our inspection. Their role was to manage the home on a short-term basis until the registered provider recruited a new registered manager. However, they were leaving the service within the week and another interim manager was due to take over their role.

Insufficient staffing levels were impacting on all aspects of the service and the system used to define and deploy staff around the service was not robust. The regional director for the service did take action on the second day of our inspection by increasing the staffing levels on shift. However, we felt that this did not address all the concerns in this area.

Senior care staff and care deputies did not receive appropriate training to enable them to effectively and efficiently carry out their job roles and duties. Competency checks of staff performance were not being completed and meetings with staff to discuss their work performance (supervisions and appraisals) were not taking place. There was a lack of effective communication between the care staff, senior staff and management team. This meant people's health and well-being was at potential risk of harm.

The assessment, monitoring and mitigation of risk towards people who used the service with regard to accidents/incidents, medicine management, hydration, bowel care, falls, pressure care and infection control practices was not robust. This meant people's health and safety was at potential risk of harm.

The management structure within the service did not effectively support the quality assurance systems and management arrangements within the service. There was a lack of robust audits and little evidence of appropriate action being taken to improve the service. Audits completed by the registered provider and the

interim manager showed there were a number of recognised concerns with regard to documentation and people's health and well-being. However, insufficient action had been taken to mitigate these known risks.

We found that cleanliness and infection control practices within the service were not robust. We noted odours in one bedroom and saw dirty laundry in another. We spoke with relatives who had concerns about hygiene in the service.

There were systems in place to keep people safe and protect them from unlawful control or restraint. Some people who used the service were subject to a level of supervision and control that amounted to a deprivation of their liberty. We found that the interim manager had carried out an audit of people who had a standard authorisation for a deprivation of liberty safeguard in place and had determined which ones required renewing. The interim manager had begun to submit the relevant documentation to the supervisory body of the local authority, but this piece of work was not finished.

Care files were completed in an inconsistent manner, with some documentation being left blank even when people had been in the service for a number of months. Bank and agency staff were used frequently in the service, but they and the permanent staff did not always read the care plans meaning care staff lacked knowledge of people's care and support needs.

The registered provider's complaints policy and procedure was not being followed consistently. Relatives and staff felt their concerns were being ignored or not answered robustly.

We have found three breaches of regulation during this inspection in relation to safe care and treatment, good governance and staffing. We are currently considering our regulatory response to these breaches and will report on any action once it is completed.

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.

Insufficient staffing levels were impacting on all aspects of the service and the system used to define and deploy staff around the service was not robust.

People were at risk because appropriate arrangements were not in place to handle and administer medicines safely.

The assessment, monitoring and mitigation of risk towards people who used the service were not robust.

Infection control practices were not robust and this increased the risk of infection or cross infection.

Is the service effective?

Requires Improvement

The service was not always effective.

Senior care staff and care deputies employed by the service did not have the skills, knowledge and abilities to deliver care in line with people's needs.

Competency checks of staff performance were not being completed and meetings with staff to discuss their work performance (supervisions and appraisals) were not taking place.

There was a lack of effective communication between the care staff, senior staff and management team.

Decisions made on people's behalf were not made in a best interests forum as required and the principles of the Mental Capacity Act 2005 were not consistently being followed.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with respect and dignity by staff.

The care and treatment of people was not always person-centred and did not meet their needs.

Care staff did demonstrate patience with people and were able to communicate with individuals in a compassionate manner.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care files were completed in an inconsistent manner. Staff did not always read the care plans and lacked knowledge of people's care and support needs.

The registered provider's complaints policy and procedure was not being followed consistently. Relatives and staff felt their concerns were being ignored or not answered robustly.

Is the service well-led?

Inadequate

The service was not well-led.

The management team within the service did not have enough resources to effectively support the quality assurance systems and management arrangements within the service. This meant quality and safety could not be assured.

There was a lack of robust audits and little evidence of appropriate action being taken to improve the service.

Hambleton Grange

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 took place on 16 and 17 May 2017 and it was unannounced. The inspection team consisted of two adult social care inspectors and two experts-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The experts-by-experience who assisted with this inspection had knowledge and experience relating to nursing care, care of older people, and people living with dementia.

Before the inspection we spoke with the local authority safeguarding and commissioning teams to gain their views of the service. We reviewed all of the information we held about the service, including notifications, sent to us by the registered provider. Notifications are documents that the registered provider submits to the CQC to inform us of important events that happen in the service. The registered provider submitted a provider information return (PIR) in July 2016 within the given timescales for return. 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 the regional director, the interim manager, two deputy managers and nine staff including senior care staff, care staff, ancillary staff and activity staff. We spoke with nine people who used the service and five relatives. We used the Short Observational Framework Tool for inspection (SOFI). SOFI is a way of observing care to help 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 five 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 three members of staff, staff training records, policies and procedures and records of maintenance carried out on equipment.

Inadequate

Is the service safe?

Our findings

One relative said, "I don't feel that my relatives are safe in the service. I have raised issues with the local authority safeguarding team about their care and support and this is being investigated. I don't feel the service is interested; there is a failure to taken any action and to resolve things." We followed their issues up during the inspection and our findings are within this report.

People we spoke with who lived at Hambleton Grange told us they felt safe living there. One person said, "I feel safer here than when I lived at home on my own''. Another person said, 'It's alright here. I came in here with my husband, but he has since died."

There was a systematic approach to determining the number of staff and the range of skills required in order to meet the needs of people using the service and to keep them safe at all times. However, this was not effective and there were insufficient numbers of staff deployed in the service to meet people's care needs.

On 16 May 2017 we reviewed the dependency tool used by the registered provider to determine the levels of staff within the service. We found that two people who used the service did not have a dependency rating and five other people had not been reviewed properly by the care staff as they lacked the training to complete the tool. Therefore, the dependency tool did not reflect people's increased care and support needs. We asked the interim manager to review the tool and they gave us a revised dependency tool on the morning of 17 May 2017. However, the regional director then told us that the tool was not fit for purpose and a new one would be obtained from the registered provider and put into place as soon as possible.

We received the amended dependency tool as part of the remedial action plan on 18 May 2017. However, the successful use of the tool depended on the interim manager and the senior care staff and deputies knowing how to assess people's dependency levels appropriately. This level of training had not been delivered at the point of our inspection.

One person who used the service told us, ''The staff are lovely to me but there's not enough staff.'' Another person said ''I think there should be more staff, I had to wait ten minutes this morning before someone got me up.''

The service provided people with accommodation and communal spaces over three floors and each floor was staffed separately. On the ground floor were 12 bedrooms and on the first and second floors there were 19 bedrooms per floor. The ground floor unit was for people living with moderate onset dementia, the first floor was for people who were living with mild onset dementia and the second floor supported people with residential needs.

The service was observed by inspectors to be under staffed on 16 May 2017. They observed one person who used the service had dirty fingernails and another person wearing dirty clothing. Two people had not received pressure care as outlined in their care plan and recreational activities were not always taking place for the people living with dementia. Staff told us, "We are short staffed most days, even though the interim

manager tries hard to cover the shifts. The agency staff are really good and have a nice rapport with people who use the service." "People on the ground floor do not really have much interaction time with staff. We are too busy." "Difficult to do baths and showers as we need two staff for this and if that is all there is on then it leaves the lounges and other areas without cover." "We ring other floors to send staff if we need to do care tasks that require two staff, so that someone is around to answer any call bells or general requests for help."

We noted that one person who was assessed by the service to be at a high risk of falls was not being monitored when in the lounge. This was in part due to the fact that staff were working with one member of staff short on the ground floor of the service, leaving only two staff on duty on the ground floor for 12 people who were living with moderate onset dementia needs. The two senior care staff on duty and the deputy were included in the total of eight care staff on duty for 49 people present in the service at the time of our inspection. Staff were spread out over three floors and the deputy said that on the ground floor there were three people who required 2:1 support for care tasks.

We viewed four weeks of rotas leading up to our inspection and saw that there was not enough permanent staff to maintain the registered provider's minimum level of nine care staff on shift and five at night. Agency staff usage was high to cover the gaps in the shifts and the interim manager said they used the same agencies and tried to get the same staff for consistency of care. However, we saw during our inspection that agency staff did not always turn in when booked which left the service short staffed.

We spoke with the interim manager who told us that care staff were responsible for day-to-day care and support. The registered provider also expected the care staff to carry out recreational activities each day. Seven staff on duty said the care staff had to make beds, empty bins, tidy rooms and generally keep an eye on housekeeping due to the shortage of domestic staff. The regional director, who spoke with us on the second day of our inspection, said that recruitment for care staff and domestic staff was currently taking place. They acknowledged that the levels of staff on duty were not sufficient to meet people's needs and agreed to take immediate action to ameliorate this. The risk has been partially addressed by having an increase from nine to ten care staff as part of the registered provider's remedial action plan to CQC received on 18 May 2017.

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

The interim manager told us, "Coping is different to delivering a good service. We are caring, but we could be better. Things are task orientated in order to get things done. A lot of care is common sense, but the lack of leadership and training means there are some things the senior staff do not know how to do. The deputies and senior staff do not have access to the computer and they do not know how to complete notifications. Most of the systems for the service are on-line."

There was evidence that the interim manager had recorded the accidents and incidents within the service. However, we found there was no oversight or amelioration of risk for people even when they were identified by the service as at significant risk of harm through repeated falls. For example; we saw that one person had fallen six times in April 2017. We looked at the care file for this person and saw they were referred to the falls team on 24 April 2017, but their falls risk assessment dated 25 April 2017 showed this had not been completed after each fall. This meant staff had not reassessed the person's level of need for mobility. Their care plan said they should be supervised when in the lounge due to a high risk of falls. They were found to be unsupervised when we checked at 16:45 on 16 May 2017. Staff told us that as there were only two staff on the unit it was impossible to have a member of staff in the lounge area.

We spoke with the domestic staff on duty and they told us, "We do not have enough domestic staff on duty to do cleaning properly. Bedrooms are only being cleaned once or twice a week as there are two domestic staff on from 8am to 2pm when there should be four. One new domestic staff has been recruited to start next week, but the fourth member of staff keeps getting pulled onto caring duties."

We checked with the duty rotas and confirmed this. One relative told us, "My relative's room stinks. I have had to open their window as I could not stand the smell." We checked this out following our conversation and found the window open and a distinct odour about the room. Staff told us they tried to keep on top of cleaning in the bedroom, but this was an on-going problem. We saw complaints from March 2017 to May 2017 relating to concerns about the cleanliness of bedrooms and dirty laundry. The cleaning schedules from 1 May 2017 showed that bedrooms were being cleaned once a week on average, instead of the expected daily clean.

We spoke with the Regional Director on 17 May 2017 about the lack of cleaning staff. They said they had not been made aware that domestic staff were being used for care duties. They said they would look into this. This demonstrated the lack of oversight and communication between the staff, interim manager and the registered provider.

On 17 May 2017 we reviewed medicines arrangements with the deputy manager and it was identified that there were no PRN (as and when required) protocols in place for people who used the service. This meant staff were not provided with sufficient guidance to know when these medicines should be administered.

We looked at the medicine administration records (MARs) for one person which showed that they had not been given their prescribed bowel medicines since 30 April 2017. They were also on a second bowel medicine, which was prescribed on an 'as and when needed' basis (PRN) which had not been given by staff since 24 April 2017. We asked the deputy manager if they kept any records to demonstrate that this person had their bowels opened on a regular basis without this medicine; they told us that they did not keep a chart of bowel movements. The person's care file had a care plan with regard to continence issues, which identified they required bowel medicine to maintain good health. This meant senior staff were not monitoring the person's health and well-being. There was no risk management plan in place to ensure the person was not put at risk of faecal impaction, which can cause delirium and agitated behaviour in people living with dementia.

The MARs for another person who used the service showed that on two occasions in the last three weeks from 26 April to 16 May 2017 they had not received their medicine for raised blood pressure on two occasions. The medicine was prescribed once a day at 10am. There was nothing to show that staff had attempted to give the medicine later on in the day, on the two missed occasions. This meant this person did not receive their medicine as prescribed, which put their health at risk.

We found that that a third person had not been given their medicine to prevent or correct their levels of stomach acid, although it was prescribed as a regular medicine and not a PRN. They also had not been given their prescribed medicine for agitation (due to their dementia) on five occasions over the last three weeks, although again this was not a PRN medicine. This meant this person's health and well-being was put at risk of harm.

The topical medicine charts we looked at (used to record the application of external medicines such as creams) had no directions for use on the forms and only one out of the three staff teams had completed the information about safe practice actions regarding application of the medicines. A number of the charts were missing signatures, which meant we could not be assured that these medicines were being administered as

prescribed.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

Staff had received basic training on making a safeguarding alert so that they would know how to follow local safeguarding protocols. There was written information around the home about safeguarding and how people could report any safeguarding concerns. Staff said they would go to senior care staff or the interim manager if they had any issues. However, we noted that the whistle blowing policy on the wall of the staff room had no contact numbers; so if staff wished to raise concerns then they would have to ask the interim manager for the number to ring. The regional director said they would sort this out immediately and make sure the policy included the correct contact details within it.

There was on-going recruitment for care staff and domestic staff and the interim manager followed the registered provider's recruitment policy to make sure new staff were suitable to work in a care service. These included application forms, interviews, references 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.

There were contingency arrangements in place so that staff knew what to do and who to contact in the event of an emergency. The fire risk assessment for the service was up to date and reviewed yearly. The people who used the service had a personal emergency evacuation plan (PEEP) in place; a PEEP records what equipment and assistance a person would require when leaving the premises in the event of an emergency.

We 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. Clear records were maintained of daily, weekly, monthly and annual health and safety checks carried out by the staff, maintenance team and nominated contractors. These environmental checks helped to promote the safety of people who used the service.

Requires Improvement

Is the service effective?

Our findings

Senior care staff and deputies had not received training to enable them to perform their roles effectively. This had led to people who used the service, being put at risk of harm as these senior staff lacked the knowledge and skills to risk manage incidents and accidents in the home, review and recognise risks to people's well-being with regard to medicines management, hydration, pressure care, hygiene and infection control.

We discussed this with the regional director who confirmed that there was no additional training programme set up for senior care staff or deputy managers. They explained the registered provider had recognised this and a programme was in a developmental stage. So staff in charge of the units had not had enhanced training for subjects such as Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DOLs), safeguarding of adults, medicine management, risk management, care planning, record keeping, first aid, fire safety and pressure care.

We looked at records of staff induction and training to check that staff had the appropriate skills and knowledge to care for people effectively. We saw that staff completed a two week induction which included completion of training deemed by the registered provider as 'essential'. Staff told us they completed essential training such as fire safety, basic food hygiene, first aid, infection control, health and safety, medicines and safeguarding. The regional director said that moving and handling and fire safety were done as face- to-face sessions and other were done on-line via the computer. The staff we spoke with said, "The e-learning sessions are very basic and not that good. We would like more face-to-face sessions that are pitched at a higher level."

We looked at the staff training plan and saw the interim manager had made progress in the last 12 weeks to ensure care staff completed their refresher training in the essential training subjects. The majority of overdue training had been completed, although there remained some gaps.

Supervision is a process, usually a meeting, by which an organisation provides guidance and support to its staff. On 16 May 2017 we spoke with the interim manager about staff supervisions and we were given a 'Staff exception report' document which highlighted overdue supervisions. We saw that 32 out of 42 members of staff had not received regular supervision and they were overdue from eight to 252 days. We were told by the acting manager that none of the eight senior care staff and two deputies had undergone competency checks of their practice to determine if they had the required/acceptable levels of competence to carry out their roles unsupervised. The regional director told us on 17 May 2017 that none of the staff had received an appraisal of their performance in their role since the home registered with the Commission on 6 August 2015. This meant the staff did not receive appropriate support and guidance on their work performance to ensure high quality care was delivered to people who used the service.

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

We found people were at risk of their health deteriorating because staff did not carry out important interventions to prevent deterioration. The interim manager and the senior staff did not monitor or review people's pressure care and staff practice, which meant people at risk of pressure damage were put at further risk by poor communication between staff and management and staff inaction.

We spoke with staff on 16 May 2017 and were told that one person received pressure relief as they were at high risk of developing pressure sores and they were living with dementia. We looked at their care file and care documents as part of the inspection. The person's pressure sore prevention assessment carried out on 15 April 2017 by the care staff, identified them as at a very high risk of pressure damage which required monitoring and a risk reduction plan in place. Their position change record for 15 May 2017 showed no details of what pressure care was given to them during the day or the state of their skin integrity. Staff had recorded where the person was, such as wheelchair/comfy chair and bed every two hours, but not if pressure relief was given. We spoke with two staff members about this and they said the person was on a pressure relieving cushion. However, their care notes from 16 May 2017 identified that when staff were position changing the person they found no pressure cushion beneath them. This left this person at high risk of pressure damage.

We spoke with staff on 16 May 2017 and were told that another person, was being treated for a pressure sore and received input from the district nursing team. We looked at this person's care file and saw that the district nurse visits were recorded in the record of multi-disciplinary visits. We saw entries dating from December 2016 to May 2017 indicating regular visits to attend to their pressure areas. However, on 21 April 2017 the district nurse recorded that staff were to implement a chart to check if the pressure relieving bed was working and switched on as they had been informed by staff that the bed mattress pump had been turned off on 20 April 2017 and the district nurse found the person's heels had turned red again indicating pressure damage. We spoke with the interim manager about this who said they had not been notified of the incident by the staff.

We asked a member of staff for a third person's pressure chart. They told us the pressure chart had not been completed that day as they lacked the staff to carry out the pressure relief so it had not been done. We spoke to the interim manager about this and they said they would have offered their assistance if staff had raised the issue with them.

On 16 May 2017 we looked at food and fluid charts for two people who used the service. We found there was a lack of documentation of their total fluid intake and output for each day. Care files did not record how much fluid each person should be consuming so it was difficult to see how staff could monitor that people had sufficient fluids on a regular basis. The lack of monitoring and risk management meant people could be at risk of dehydration.

Staff who spoke with us had knowledge of people's needs for individuals on the units they were on, but struggled to tell us about other people in the service. However, they quickly obtained the information we needed. We found that communication between the staff and the management team was not effective. The communication handover books were poorly recorded in and we found that the daily handover between day and night shifts was verbal so there was no written record of what information was passed over. The documentation we saw only recorded what needed to be done; there was no written evidence of who did what and when or if there was an outcome. This increased the risk of harm to people who used the service as there was a lack of oversight and monitoring to ensure people's changing needs were being identified and met.

We saw that input and advice from external health care professionals was recorded on the multi-disciplinary

visit records in people's care files, but the information was not always used to develop the person's care plans. Discussion with the interim manager indicated this had been noted on a recent quality audit and would be addressed as part of staff development.

People had been seen by dieticians or the speech and language therapy team (SALT) for assessment on their swallowing / eating problems. Weekly weights were being monitored, but some of the documentation such as amount of weight lost, nutritional risk assessment, care plan updated and referral made was blank. This made it difficult to see what action if any had been made in response to the weight loss. Weekly weights were not being completed as per one person's plan of care and information from their GP had not been incorporated into the relevant care plans.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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. 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. We saw that the week before our visit the interim manager had checked through all the care files in the service to understand who had a DOLs in place and who required an application to be made. We saw, from evidence provided by the interim manager, that some DOLs had lapsed as a renewal form had not been submitted. At the time of our inspection the interim manager was working through the applications to make sure new applications were submitted to the supervisory body of the local authority. This work has not completed but the interim manager's actions meant the risk of restraining people without appropriate authorisation was reduced.

When we looked at people's care files we saw that it was not clear on the consent to care documents if the person signing these had capacity or if the relative signing had a Lasting Power of Attorney where they had been registered with the Office of the Public Guardian (OPG). The interim manager showed us where they had written to relatives asking for evidence of their LPA so a copy could be kept with people's files. They said they had made a start on assessing people's capacity, but the MCA assessments were not fully completed.

We found that there were no Best Interests Meetings recorded when decisions about care were made by the person using the service. For example, when people were resistant to personal care, what action was appropriate for the staff to take to ensure people were clean and comfortable. We were told by the deputy manager that sometimes one person who lacked capacity refused their medicines. However, there was no information in this person's care file to indicate that any discussion had taken place with their GP or family (best interest meeting) and no decision made about what action to take if they continued to refuse their medicines. There was no evidence to suggest this person was at immediate risk of harm, but there was a potential risk of harm.

These concerns about MCA and DOLs were discussed with the regional director at the end of the inspection who said they would ensure the new interim manager continued to improve this area of care.

People said they were consulted about their care and staff asked for consent before carrying out any tasks. People told us, "We are always asked if it is okay before the staff do anything for you." "The staff always check if you are okay with things. For example, they say things like 'we would like to ask your opinion about this'" and "Staff always ask you first before doing anything."

One person we spoke with said, "The food is good and there is always two choices." Another person who used the service said, ''I am a diabetic, and I always get more than enough food.''

Our observation of the lunch time meal showed that there was a relaxed atmosphere that helped people enjoy their meals. Staff were attentive, kind and respectful and second helpings were offered to those who wanted a bit more to eat. We saw that people were offered a choice of meals, and when people did not like what was offered the staff were proactive at offering alternatives. Special diets were catered for and people we spoke with said they enjoyed the food offered to them. The food looked and smelt appetising, portion sizes were good and everyone was allowed to eat at their own pace.

We were shown menu plans which gave people the choice of meals. Snacks between meals were offered and relatives and people who used the service commented on the, "Unbelievable cakes" with afternoon tea. We observed menu boards with the day's meals displayed on the white board in the dining area. We spoke with the kitchen manager and observed a four-week rolling menu; a list of people's allergies and dietary requirements which were displayed in the kitchen. There was a choice of five fruit/vegetables daily and calorific supplements in the form of milkshakes for people who required additional calories. Everything was homemade and pureed food was always available if required. The kitchen had recently undergone an inspection from the environmental health team of the local council. The service was awarded five stars (very good) with no recommendations, we were shown the inspection report.

Requires Improvement

Is the service caring?

Our findings

People we spoke with who lived at the home said, ''The staff are lovely to me,'' ''They are very good, they will do anything to help you, in any way'' and ''I broke my glasses and one of the girls took them and got them repaired for me. I thought that was so kind.'' We observed care interactions that were kind, patient and sensitive.

One visitor to the service told us, "I love coming here. I see people on all three floors of the service and I feel staff have a really good interaction with people who live here." We observed that staff used first names when talking to people who used the service. The majority of people were dressed nicely (see exceptions in the paragraph below) and most people wore shoes (not slippers), which aided their mobility when moving around the service. We observed people who wanted to mobilise independently, but slowly, being allowed to do so.

Although people who used the service said they felt the staff protected their privacy and dignity we found care practices were not consistent in promoting this. We saw one person sat in grubby clothing and another person had dirty laundry left in their wardrobe. This was not due to the laundry service, but more the lack of care staff, as we saw clean laundry delivered to rooms. Washed and ironed garments were hung on numbered coat hangers and the laundry staff knocked on doors before entering rooms. We saw one person with dirty fingernails. They were happily talking to a member of staff and they told us, "Oh yes, I am fine. I forget things sometimes and I have a terrible memory." We mentioned the condition of the person's nails to the staff on duty and they said they would give the person appropriate nail care immediately. We noted that other people were nicely dressed in coordinating clothes and they wore jewellery to match.

We observed that the poor quality of hygiene and cleanliness in parts of the service meant people were living in malodourous rooms which, although they could not comment on themselves due to their lack of capacity due to living with dementia, impacted on their relatives. One relative told us they could not bear to stay in the bedroom due to the odours and this meant a lack of privacy for conversations as the alternative was using the communal spaces.

The provider had a policy and procedure for promoting equality and diversity within the service. People told us that staff treated them on an equal basis and equality and diversity information such as gender, race, religion, nationality and sexual orientation were recorded in the care files. One visitor told us, "My relative does not like male care staff delivering their personal care. This was discussed with the care staff and now they are only attended to by female care staff." We saw this was documented in the person's care file.

We saw that a number of people using the service had different faiths. There was a prayer room on the second floor of the service, although staff said this was only used on a Sunday for a church service. Visitors and people living in the service confirmed that they were able to take part in services in the home and information about the next Methodist Church service was on display on the notice board.

There was no one in the service who was on end of life care at the time of our inspection.

The interim manager understood the role of advocacy and had contact details available if anyone who used the service required the support of an advocate. An advocate is someone who supports people, particularly those who are most vulnerable in society, to ensure that their voice is heard on issues that are important to them.

We saw that people were kept up to date with what was going on within the service. We observed an information board with a weekly plan of recreational activities; times and venue of social committee meetings and minutes of previous meeting; weekly monthly competitions and menus. We attended a meeting for people and relatives during our inspection and found that this was an open forum where people could express their views and opinions about the service.

We found information in the service was not stored appropriately to ensure it remained confidential. Care files were locked away in cupboards in the dining rooms, but we saw an unlocked filing cabinet in a hallway, which included personal details of staff. It was also partially blocking a exit route. We asked the administrator to lock this and later saw it had been moved to an office. We also found a filing cabinet containing old notes that had been evaluated and filed, which had been left open in the kitchen area of one dining room. We asked staff to lock this.

Requires Improvement

Is the service responsive?

Our findings

The service was not responsive around some aspects of care. We found that people's care plans did not always clearly describe their needs or record the care being given.

We looked at five care files, associated risk assessments and additional care documents such as food and fluid charts and repositioning records. Checks of the care records showed that care staff needed to take care to use appropriate language when describing care needs and documenting the care given on a daily basis. For example, words such as "Bum" and "Wandering" were used.

We have already described in the effective section of the report the issues we found with food and fluid charts and repositioning records. Further concerns with the care records included the fact that at least two of the five files we viewed had missing information in them, even though the people who used the service had been in residence for some months.

In one file there was no information about future wishes regarding death and dying even though the person had capacity to discuss this. Another file had a care plan that documented the person lived with dementia and depression, but the care plan did not explain the issues affecting this person or how staff were to meet their needs and promote their well-being. This second care file also had nothing recorded about the person's social, religious and cultural activities, their life history was left blank as was their future wishes document.

We found that dependency assessments completed by the senior care staff and deputies and reviewed monthly were not accurate and did not reflect the changing needs of people who used the service.

Staff, including agency staff and bank staff did not find the information in the care plans easy to read. They told us these documents were bulky and time consuming to navigate through. One member of staff told us, "Sometimes I do look at them, but more often I ask the senior care staff on duty for changes. I rely on this and I have not looked at them today." We saw one member of staff offering a person with diabetes a chocolate ice-cream as a snack. Although people with diabetes can have a certain amount of sugar in their diet, the member of staff when asked did not know the person had diabetes. We assessed that this lack of knowledge meant people were put at potential risk of harm.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

The provider's quality audit completed in February 2017 identified that complaints needed to be addressed correctly. The action plan produced from the audit said that all complainants should be sent a holding letter, response letter and the interim manager must ensure complaints were well documented and the outcome recorded. Our checks of the complaints folder showed that the interim manager had made a start on this, but not all were completed.

We spoke with one relative who told us that they had complained at least six times about their parent's "Dirty clothes," but their complaint was never resolved. They had just found four pairs of dirty trousers in their parent's wardrobe and mentioned that they were going to complain to the care home provider if this was not resolved. Their parent, we observed, was well dressed, their white blouse was clean although their trousers were creased and a little stained around the knees. The relative did mention that apart from this their parent was generally well cared for and staff were "Brilliant."

We found there continued to be poor practice, when issues had been previously raised by relatives, in relation to malodour in bedrooms, people wearing dirty clothing and dirty clothing being left in people's wardrobes.

On 16 May 2017 the inspectors were approached by a visitor who said they did not feel their two relatives who used the service were safe. They had made a complaint to the service on 27 March 2017 about one relative's bedroom being covered in faeces and dirty in general. The visitor said their second relative's bedroom, "Stank" on 16 May 2017 so much so they had to open the windows. We investigated this and found malodour in the bedroom, despite staff having cleaned the floors. One member of staff told us that staff struggled to control the odour despite regular cleaning.

Further complaints were received by the service from two different relatives on 4 March 2017 and 27 March 2017 about their relatives being dressed in dirty clothing and dirty clothing being left in bedrooms each night. On 17 May 2017 we reviewed the care file for one person who used the service and saw that their care plan for personal hygiene stated they were fairly independent, but staff must prompt them to change clothes. It also stated that the person would try to wash their own underclothes and staff must ensure these went to the laundry. However, on viewing their bedroom we found numerous items of dirty clothing left in the wardrobe. We found that staff were not following the care plans and did not ensure people were free from the risk of poor hygiene and cross-infection.

People we spoke with said that staff really cared about them and that care was centred around their needs. Some people knew they had a care file, but none knew what was in it. None of the people we spoke with had made a complaint about their care, but all said they would speak to one of the care workers or deputy manager should they have a problem.

We observed an information board with a weekly plan of activities; times and venue of social committee meetings and minutes of previous meeting; weekly monthly competitions and menus. When asked about activities, one person said ''We have a sing-song, and animals come in sometimes - I go to see them. There's something on each week.'' Another person said ''There's lots of activities but I choose not to join in. Although yesterday, one of the staff took me out in my wheelchair for a walk.'' Every person we spoke with enjoyed the varied entertainment available especially the VE day where they were each giving flags to wave and the opportunity to dance.

There was one activity coordinator who worked across five homes. The registered provider had expectations that the care staff would carry out activities on a daily basis. People enjoyed a 'pop-up' restaurant each month offering people a taste of different cuisines such as French and Italian. We also saw posters for a McMillan Coffee morning. People had access to a small shop in the home which was run by the staff. People could buy an ice-lolly or toiletry items from the shop. There was also a mini mobile nail bar – the care staff usually operated this and we saw a lot of the female service users had their nails painted and polished.

The activity coordinator did carry out some activities and those people able to access what was on offer enjoyed them, but there was no evidence that everyone had this experience. During our inspection when the

home was short staffed, we did not see appropriate social activities for people living with dementia taking place. A number of people were observed asleep in the lounges throughout the day or sat with nothing to do. This was mentioned during the 'residents and families meeting' held on 16 May 2017. One visitor stated they had never seen their relative involved in an activity. The interim manager and care staff said this was because the relative was always asleep when the activities co-ordinator was on site. The interim manager decided that staff would survey everyone who lived at Hambleton Grange and ask if they wish to be woken up for activities.

Inadequate

Is the service well-led?

Our findings

The registered provider is required to have a registered manager in post. The service had been without a registered manager since April 2016. Since then the service had had four interim managers. We have written to the provider about this separately to this inspection.

The latest interim manager had been in post 12 weeks from the date of 27 February 2017. Their role was to manage the home on a short-term basis until the registered provider recruited a new registered manager. However, they were leaving the service within the week and another interim manager was due to take over their role.

The interim manager told us that the provider's representatives carried out a quality audit visit every six to eight weeks and the interim manager's responsibility was to send an action plan update each week to the provider showing what progress they had made. We found that they were beginning to make changes, but these were not sufficient in the three months to ensure the health and safety of people who used the service. We noted that progress in taking action on the issues highlighted in the provider's audits was slow, due to the frequent changes of interim managers and the lack of appropriately trained deputies with supernumerary hours to give the interim manager assistance. This meant there was little evidence to show that the provider and interim managers had mitigated the risks to people who used the service of receiving non-compliant care and treatment.

We had a discussion with the regional director on 17 May 2017 about how the lack of appropriate stable management had impacted on the quality of the service. They told us that they had been employed by the provider in October 2016 and prior to this date there had been no external quality assurance systems in place. They said they had accepted the weekly updates from the interim manager at face value and had not carried out further checks to see for themselves how the service was progressing. The regional director said they recognised there should have been more spot checks on the service and that these would be carried out in the future. They told us they had been actively trying to recruit an appropriately qualified manager for the service, but had yet to find a suitable candidate who met their criteria. They completed a remedial action plan on 18 May 2017 setting out how they would move the service forward with regard to management of the service and staffing hours.

We found during this inspection that staff supervision, appraisals and development through structured training and support was not taking place. The staff lacked the knowledge and skills to recognise risks to people's health and safety and their working practice did not always protect people who used the service from risk of harm.

Staff told us, "Staff morale is really low, at breaking point. The interim manager is good, but cannot spend much time on the floor helping out." People we spoke with who lived at the service said they knew who the deputy managers were, but were not sure who the interim manager was.

Feedback from people who used the service, relatives, health care professionals and staff was usually

obtained through the use of satisfaction questionnaires, meetings and staff supervision sessions. One visitor we spoke with said, "Communication between the service management and families is poor." We observed a relative's and resident's meeting took place during our inspection and there was an opportunity for people to express their opinions at this meeting. However, staff told us that their concerns, raised during their staff meetings, were being ignored by the registered provider especially about the staffing levels in the service. We saw from meeting minutes that when a member of the management team from the provider's head office had attended the meetings where concerns were raised, nothing had changed within the service.

We asked the regional director about this who said they were unaware of the issues being raised and nothing had been fed back to them about the staffing issues. This highlighted the lack of good communication between management and staff.

As part of our planning for this inspection we spoke with the local council's quality assurance team and the safeguarding team about the service. They told us they had carried out a monitoring visit in February and April 2017 due to concerns raised through safeguarding about the poor care and support people were receiving. Their last report highlighted a number of recommendations for improvements to the service which mirrored many of the issues we found during our inspection. For example, the council's monitoring report referred to issues around supervisions, staffing levels, dependency tool, staff training, DOLs, documentation of care, hydration and nutrition, call bells and recording of positional changes.

From February to May 2017 the interim manager had attended a number of safeguarding meetings with the local council safeguarding team to discuss concerns within the service.So prior to our inspection the provider and interim manager were made aware of shortcomings in the service, but this did not result in urgent action being taken by the management team to improve practice within the service.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care was being delivered in ways that exposed service users to significant risks to their health, safety and welfare. Reasonable and practicable action was not being taken to mitigate those risks. The lack of governance and oversight within the service led to service users continuing to be placed at risk of harm. There was insufficient suitably skilled and experienced senior staff and deputies carrying on at the location and this meant, that service users were being exposed to the risk of unsafe care and treatment Regulation 12 (1) (2) (a) (b) (c) (g)(h)

The enforcement action we took:

Section 31 Urgent imposed condition on the registered provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance A lack of governance and oversight within the service meant effective systems and processes to assess and monitor the compliance of the service were not in place. The registered provider failed to assess, monitor and mitigate risk to the health, safety and welfare of service users and failed to maintain accurate and complete records in respect of each service user.

Regulation 17(1) (2)

The enforcement action we took:

Section 31 Urgent imposed condition on the registered provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed in the service to meet people's care and treatment needs. The registered provider did not have a systematic approach to determining the number of staff and the range of skills required in order to meet the needs of people using the service and to keep them safe at all times. The registered provider failed to ensure staff received appropriate support, training, supervision and appraisal as is necessary for them to carry out the duties they are employed to perform. Regulation 18)1)(2)(a)

The enforcement action we took:

Section 31 urgent imposed condition on the registered provider's registration. Notice of Decision issued.