

Sandylane Limited

Sandy Lane Hotel

Inspection report

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Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Requires improvement



Is the service caring?

Good



Is the service responsive?

Requires improvement



Is the service well-led?

Requires improvement



Overall summary

We carried out this inspection on 21 December 2015. 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.

The inspection was unannounced; which meant that the staff and registered provider did not know that we would be visiting.

The last inspection was carried out 4 November 2014; at that inspection Sandy Lane Hotel was found to be compliant with the regulations we looked at.

Sandy Lane Hotel is a care home in Bridlington in the East Riding of Yorkshire. The home is registered to provide accommodation and personal care for 31 people, some of whom may be living with dementia. Accommodation is provided over three floors. A passenger lift provides access between floors. There are 30 bedrooms, one of which is a twin room and all have en-suite toilet facilities. There are three lounges and two dining rooms throughout the home and bathrooms on each floor.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager who was not registered with the Care Quality Commission (CQC). However, they had submitted

Summary of findings

an application for registration. 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.

The home had a system in place for ordering, administering and disposing of medicines. However we found that people did not always receive their medication as prescribed, medicines were not safely stored and the procedure for disposing of medicines had not always been followed. This was a breach of a regulation. You can see what action we told the provider to take at the back of the full version of the report.

We found that the homes premises were not always clean and well maintained. This was a breach of a regulation. You can see what action we told the provider to take at the back of the full version of the report.

We saw that staff had received an induction a prior to starting work within the home. However, we found that a high number of staff had not completed refresher training in a variety of topics. This was a breach of a regulation. You can see what action we told the provider to take at the back of the full version of the report.

The manager understood the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act (MCA) (2005) guidelines had been fully followed. However we found that the manager and registered provider had failed to notify the CQC of an application to deprive a service user of their liberty. This was a breach of a regulation. You can see what action we told the provider to take at the back of the full version of the report.

We found the provider did not have an effective process of auditing in place to check that the systems at the home were being followed and people were receiving appropriate care and support. This was a breach of a regulation. You can see what action we told the provider to take at the back of the full version of the report.

We saw that there were sufficient numbers of staff on duty and people's needs were being met. However we made a recommendation regarding the deployment of staff during busy periods of the day.

We found that people were protected from the risks of harm or abuse because the registered provider had effective systems in place to manage any safeguarding issues. Staff understood their responsibilities in respect of protecting people from the risk of harm; however they required refresher training in safeguarding adults from abuse.

Assessments of risk had been completed for each person and plans had been put in place to manage identified risks. Incidents and accidents in the home were accurately recorded and monitored monthly.

We found that effective recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work so that only people considered suitable to work with vulnerable people had been employed.

Staff told us they felt well supported by the manager. They told us they received formal supervision, but could also approach the manager with any concerns at any time. However we found that supervisions and appraisals were not always effective at developing the staff team and we made a recommendation regarding this.

People's nutritional needs were met. However, we found the lunchtime experience for people was inconsistent due the deployment of staff. We made a recommendation regarding this.

People were supported to maintain good health and had access to healthcare professionals and services. People were encouraged to have regular health checks and were accompanied by staff or relatives to hospital appointments when necessary.

We observed good interactions between people who used the service and the care staff throughout the inspection. We saw that people were treated with respect and that they were supported to make choices about how their care was provided.

We saw that people's independence was promoted by the homes staff and that where possible people were encouraged to do things for themselves.

People had their health and social care needs assessed and care and support was planned and delivered in line

Summary of findings

with their individual care needs. The care plans were individualised to include preferences, likes and dislikes and contained detailed information about how each person should be supported.

The home employed an activity coordinator and offered activities for people to be involved in. People were also supported to go out of the home on day trips or to access facilities in the local community. However, people told us they would like more activities to be offered.

People's comments and complaints were responded to appropriately and there were systems in place to seek feedback from people and their relatives about the service provided. However we did not see how this feedback was used to improve the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Staff displayed a good understanding of the different types of abuse and could explain how to recognise and respond to signs of abuse to keep people safe from harm.

We saw that there were sufficient numbers of staff employed but recommended that the way they were deployed should be reconsidered.

The home had a system in place for ordering, administering, storing and disposing of medication. However this was not always effectively followed.

Risk assessments were in place and reviewed regularly which meant they reflected the needs of people living in the home.

We found that the homes premises were not always clean and well maintained.

Requires improvement



Is the service effective?

The service was not always effective.

Staff had not received up to date training in a variety of topics within the last three years.

The manager was able to show they had an understanding of

Deprivation of Liberty Safeguards (DoLS) and the Mental

Capacity Act (MCA) (2005). However they had failed to notify the CQC when they had made an application to deprive a service user of their liberty.

We saw peoples nutritional needs were met and that when people required support to eat and drink this was provided. However, we found the lunchtime experience for people in the home was inconsistent.

People's health needs were met and people who used the service received, where required, additional treatment from healthcare professionals.

Requires improvement



Is the service caring?

The service was caring.

We observed good interactions between people who used the service and the care staff throughout the inspection.

People were treated with respect and staff were knowledgeable about people's support needs.

People were offered choices about their care, daily routines and food and drink.

Good



Summary of findings

We saw that people's independence was promoted by the homes staff and that where possible people were encouraged to do things for themselves

Is the service responsive?

The service was not always responsive.

People had their health and social care needs assessed and plans of care were developed to guide staff in how to support people.

We saw some people were encouraged and supported to take part in a range of activities. However people told us that there were not enough activities provided.

There was a complaints procedure in place and people were informed about how to make a complaint if they were dissatisfied with the service provided.

Requires improvement



Is the service well-led?

The service was not always well led.

The service did not have effective systems in place to monitor and improve the quality of the service.

Staff and people who visited the service told us they found the manager to be supportive and felt able to approach them if they needed to.

There were sufficient opportunities for people who used the service and their relatives to express their views about the care and the quality of the service provided.

Requires improvement



Sandy Lane Hotel

Detailed findings

Background to this inspection

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

This inspection was carried out on 21 December 2015 and was unannounced. The inspection team consisted of two Adult Social Care (ACS) inspectors.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider and information we had received from the local authorities that commission a service from the home. We also contacted the local authority safeguarding adults and quality monitoring teams to enquire about any recent involvement they had with the home.

The provider was not asked to submit a Provider Information Return (PIR) prior to the inspection, as this was not a planned inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with four visiting relatives, three members of care staff, the manager and the regional manager. We spent time observing the interaction between people who lived at the home, relatives and staff.

We looked at all areas of the home, including bedrooms (with people's permission) and office accommodation. We also spent time looking at records, which included the care records for three people, handover records, the incident / accident book, supervision and training records of three members of staff, staff rotas, and quality assurance audits and action plans.

Is the service safe?

Our findings

We were told that only the homes management and senior care workers were responsible for the administration of medicines. We saw that they had all completed training, however only person had received refresher training within the last three years and there was no evidence that competency checks had occurred in the same period. This was a breach of regulation and is covered in another section of this report.

All medicines were stored in either the medication trolley or the medication fridge; the temperature of the medication room and fridge were checked daily. However we found that although the fridge was kept at the correct temperature, the temperature of the room was repeatedly recorded above 25°C, the recommended storage temperature for most medicines. This meant that medicines were not stored safely.

We saw that all medicine delivered into the home was checked and signed for by staff. The local pharmacist dispensed people's medicines into a monitored dosage system (MDS) prior to delivery. A MDS is a way in which medication is repackaged into a "box" or "blister system" which indicates the days of the week and times of day medicines should be taken. We saw the blister packs were colour coded to indicate the time of day the medicines needed to be administered.

Some prescription medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs [CDs] and there are strict legal controls to govern how they are prescribed, stored and administered. We checked the storage of CDs and noted they were stored securely. We saw that CDs were stored separately to other medicines in a secure cabinet. We checked the CDs on the premises and found that the number remaining of each tallied with the number recorded in the CD book.

We looked at the medicine systems and records for people living in the home. Any medicines which had been given were recorded on their medicine administration records (MARs) and were signed for by staff. Codes were used to record any medicines which had not been administered to state the reason this had not been given, including when medication had been refused. We saw that body maps

were being used to record where on the body pain relief patches needed to be adhered to ensure that staff did not always place them in the same area, and also to identify where topical creams needed to be applied.

People told us that they received their medication at the right times, however when we observed the medication round we saw that this was not the case. One person required some medicine to be taken 20 minutes before meal times. However, we saw that this person had already eaten their meal when they were given their medication. This meant not all people were receiving their medication as prescribed.

We saw the home had a system in place for the disposal of unwanted or unused medicines. However we found that three tablets [two of which were a controlled drug] had been dispensed into a medication pot for administration but had not been given to the person concerned. These medicines should have been returned to the pharmacy for disposal but instead were found in one of the medication cabinets. We discussed this with the member of staff responsible who told us that the person who they belonged to was no longer in the home and it was down to human error that these had not been returned as per the homes medication policy. We discussed this with manager who told us that this would be addressed through supervision to ensure that all people responsible for administering medication were clear of the correct procedure for the safe disposal of medicines.

This was a breach of Regulation 12. Safe Care and Treatment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that areas of the home had recently been decorated, new carpets had been fitted and these areas had a warm and homely feel. However we saw that other areas of the home required more immediate attention to ensure they were at a satisfactory standard. We saw that people had been able to personalise their rooms and although they felt homely a number were in need of redecoration to provide a more pleasant environment for people living there. We spoke to one relative who told us "We had to ask for [Name] room to be deep cleaned and the domestic staff did do this for us."

On arrival we found that the 1st floor toilet had no soap so people using this facility were unable to effectively wash their hands. This was also found to be the case in the sluice

Is the service safe?

room. On the second floor the toilet basin was stained, light switches were dirty and the cold water tap could not be turned off. We also noted that throughout the day a strong malodour was intermittently present in various locations around the home. We noted that although the home had replaced the in the lounge that the arms of these appeared dirty and required shampooing. We saw no evidence that cleaning schedules had been utilised and that regular deep cleaning had taken place in the home.

This was a breach of Regulation 12. Safe care and treatment of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that in the sluice room there was a leaking pipe, the flooring was cracked, walls were stained and a heavily soiled cupboard door was propped against a wall. We saw that the ceilings in corridors were cracked and required repair and the window on the first floor was cracked and the frame appeared to be warped preventing it from closing fully. We also saw that on the stairs linking the three floors the paint was peeling off and there was evidence of damp, although this area of the home was not accessed by the people living there. We looked in the linen cupboard and saw that although this was clean and tidy some of the linen looked old and worn and required replacing

This was a breach of Regulation 15. Premises and equipment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that there were cleaning rotas available for kitchen staff and these were being adhered to. The home had achieved a food hygiene rating of four which the staff were disappointed with as they had pride in the cleanliness of the kitchen. However they explained that the fridge was not working on the day of the inspection therefore they were unable to be awarded with the highest score of five.

We were told there was a business plan in place which identified what areas of the home required improving and saw an action plan was in place to address some of the concerns that had been identified. This included a programme of room redecoration, the purchase of new bed linen and towels, the purchase of new pictures in communal areas of the home, the redecoration of communal areas. We also saw that quotes had been obtained to address some of the homes damp issues.

However we did not see that any of the improvements mentioned had a specific timescale for completion, therefore it was unclear by what date all of the improvements would be completed.

The service had policies and procedures in place to guide staff in safeguarding people from abuse. We saw the manager used the local authorities safeguarding tool to decide when they needed to inform the safeguarding team of an incident, accident or an allegation of abuse. We saw that safeguarding concerns were recorded and submitted to both the local safeguarding team and the Care Quality Commission (CQC) as part of the registered provider's statutory duty to report these types of incidents.

We spoke with three members of staff about safeguarding, how they would identify abuse and the steps they would take if they witnessed abuse. We asked staff to tell us about their understanding of the safeguarding process. Staff gave us appropriate responses and told us they would initially report any incidents to the manager or the senior care worker on shift and they also knew how to take it further if needed. One member of staff told us "I keep people safe by following the homes procedures, I ensure residents are eating and drinking properly, taking their medication on time and would report anything I thought was abusive to the manager." Another said "If I saw something that wasn't right I would report it to the management. I reported something a few years ago and I would do it again."

All accidents and incidents were collated, accurately recorded and included detailed information on the type of accident, whether any injuries were sustained and what action was taken. These were audited on a monthly basis. This provided opportunity for the manager to monitor whether any patterns were developing and put in appropriate interventions to minimise the risk of them occurring again. For example we saw that one person living in the home had experienced three falls in a short period of time. This had been referred to the GP who had then arranged for the falls team to complete a falls assessment to minimise the risk of future falls.

We saw the home had systems in place to ensure that risks were minimised. Care plans contained risk assessments that were individual to each person's specific needs. This included an assessment of risk for falls, pressure care, mobility and nutritional status. We saw Personal Emergency Evacuation Plans (PEEP) for all of the people

Is the service safe?

living at the service. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency.

All the people we spoke with who lived in the home told us that they were happy, felt well cared for and were safe. One person said “I have no complaints, the staff are very good and I feel very lucky to live here.” Another said “I love being here.” We spoke with one relative who told us “[Name] needs checking every 2 hours through the night to make sure they are safe, I’m confident that this happens” and “The home is more proactive than reactive; this helps to prevent accidents.” A member of staff told us “We keep people safe by keeping people’s rooms tidy so they don’t trip over anything and make sure they have enough food and drink.”

We confirmed that checks of the building and equipment were carried out to ensure people’s health and safety was protected. We saw documentation and certificates to show that relevant checks had been carried out on the electrical circuits, portable appliance testing (PAT), fire extinguishers, emergency lighting and all lifting equipment including hoists. We saw that a suitable fire risk assessment was in place and regular checks of the fire alarm were carried out to ensure that it was in safe working order. We also saw that regular fire drills took place to ensure that staff knew how to respond in the event of an emergency. This showed that the registered provider had taken appropriate steps to protect people who used the service against the risks of unsafe or unsuitable premises.

We asked the manager how they determined the number of staff they needed to safely meet the needs of the people living in the home. The manager told us that they calculated the number of staff required based on the number of people living in the home and their individual level of need. They told us that if they were ever short of staff due to sickness or annual leave they were able to move staff between the two homes the provider owned and this avoided the need for the use of agency staff. The area manager told us “We need to know people inside out so don’t use agency staff as they often send different people each time.”

The people we spoke with gave us a mixed response when asked about staffing levels. One person living at the home told us “I wanted to go out for a new watch, however I was

told there were not enough staff to take me.” Another said “At night when I press my buzzer, the staff come straight away. I’m not left waiting.” On the day of the inspection we noted that call bells were responded to promptly.

Two staff member told us they felt another member of staff would be beneficial. One said “I feel at times there is need for an extra member of staff. A ‘floating’ member of staff between the three floors at peak times would be good.” Another said “We could do with a ‘floating’ member of staff, especially at mealtimes, this would allow more time to be given to residents who may need feeding or coaxing with their meals. This would benefit the resident’s and the staff.” One relative told us “You can be here an hour and not see a member of staff.” However, they did feel their relative was receiving the right level of care.

We discussed this with the manager and the regional manager. They told us that the people living on the ground floor and in the flats were mostly independent and the lounge they utilised during the day was directly opposite the manager’s office. This meant the manager was on hand should they require any assistance. This enabled a senior care worker to lead three members of care staff across the first and second floors of the home.

On the day of the inspection we found that the morning shift was covered by the manager, a deputy manager, three care staff, a cook, a kitchen assistant, a handyperson, two domestic assistants and a member of administration staff. From our observations we felt that there were sufficient staff in the building throughout the day. However we felt that the way in which they were deployed could be improved across the busier times of the day, specifically mornings and mealtimes. The homes kitchen staff were not utilised to provide support at mealtimes. This meant that there were only two care staff available to serve all meals and also provide people with the support and assistance they required. This meant it was difficult to ensure that all people received their food in good time and in a pleasant atmosphere.

We recommend the home reviews the deployment of staff to ensure that people’s needs are met during busy periods including mealtimes.

We looked at the recruitment records for three staff members. We found the recruitment process was robust and all employment checks had been completed. Application forms were completed, references obtained

Is the service safe?

and checks made with the disclosure and barring service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and ensured that people who used the service were not exposed to staff that were barred from

working with vulnerable adults. We did note that some of the DBS checks had not been renewed for several years. Interviews were carried out and staff were provided with job descriptions and terms and conditions. This helped to ensure staff knew what was expected of them.

Is the service effective?

Our findings

People we spoke with felt the homes care staff had the necessary skills and training to effectively carry out their designated roles. One member of staff told us “Before I started working in the home I had to complete an induction and I also shadowed other staff members for two shifts.” We saw a copy of the induction for a member of staff and saw this covered a range of topics including the company’s philosophy, code of conduct, health and safety and also more practical training including supporting people with personal care, moving and handling, pressure care, assisting people to eat and customer service.

A health and social care professional told us “I’m happy with the homes environment and the staff’s level of expertise.”

Despite people telling us that they felt the staff were well trained and staff telling us they had received training, when we looked at the homes training records we found that in the last three years less than 38% of staff had completed training in Safeguarding adults from abuse and moving and handling. We also saw as few as 25% had attended training in infection control, food hygiene and first aid in the same period. None of the staff had received specialist training in behaviour that could challenge the service or dementia awareness since September 2012. We also saw that only six of the staff had completed NVQ level 2 which was below the registered provider’s own expectation that 51% of staff should hold this qualification.

We were told that only the homes management and senior care workers were responsible for the administration of medicines. We saw that they had all completed training, however only one person had received refresher training within the last three years and there was no evidence that competency checks had occurred in the same period

This was a breach of Regulation 18. Staffing, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed this with the manager and they told us, after the previous manager had left the service, they had inherited a backlog of out of date training. This had been identified as a priority and they had started the process of booking training courses for the staff. Since taking over they had registered six more people on NVQ level 2 and had also implemented the Care Certificate for new starters. They

informed us that they had already arranged fire safety training for all staff and that more training courses were booked for the New Year. Despite the lack of recent training the manager did not feel that that staff lacked the required skills to safely carry out their roles. However they recognised the need to ensure that all staff were kept up to date with the most current advice and training.

Staff told us they received regular supervision. One member of staff said “I can speak to my supervisor and go to [Name] with any issues. I know [Name] would go to [Name] (the manager) with any concerns I had.” We looked at staff files and found that since the manager had been in post all staff had received supervision on a two monthly basis. We also saw staff had completed an annual appraisal. These meetings were used an opportunity to discuss any current issues, areas for improvement and any training needs.

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 found two people using the service were subject to a DoLS authorisation and the manager was awaiting the outcome of one additional application that had been made to the local authority. The Care Quality Commission monitors the operation of the DoLS which applies to care services and it is a requirement of the manager to ensure that the CQC is notified of all DoLS authorisations. Prior to the inspection we had checked and found that no notifications had been received from the home.

This was a breach of Regulation 18. Notification of other incidents, of The Care Quality Commission (Registration) Regulations 2009.

Is the service effective?

We looked at training records and found that none of the staff had received training in the MCA. However we did observe that staff were aware of the need to seek consent before performing any care interventions with people. We also saw that although care files had a 'consent to care' form present a number of these had not been signed either by the person when they had capacity or by the person's representative when they lacked the capacity to agree to the contents of the care plan.

We discussed this with the manager and they told us that they had inherited training schedules and care plans that were largely out of date and they had been working hard to ensure that they were all updated within reasonable time scales. They also told us that some people who lived in the home had families who lived away or had little contact with them; therefore it was not always easy for them to discuss the contents of people care plans or for them to consent to way the care was delivered. They said they would consider using advocates in the future to ensure that that consent was obtained.

The manager told us that they did not use restraint within the home and people had behaviour management plans in place to guide staff on how to manage situations if people became agitated or showed signs of distress. We saw that the plans advised staff to either back away, distract or refocus the person displaying these types of behaviours. This was confirmed by the staff we spoke with who told us that if people become agitated they ensured they are safe, left them and returned later on to see if they have settled down. This avoided the need for confrontation and meant that restraint was not needed.

At lunchtime we saw that people were offered a choice of soup and a choice of a hot meal or an alternative such as sandwiches. They were also offered a choice of dessert. We saw staff let people decide where they wanted to sit for their meal and also ensured where possible that those people who chose to stay in their rooms received their food at the same time as people eating in the main dining room.

We observed the lunchtime meal on the first floor and found the meal time experience to be inconsistent. We saw that one of the people living in the home required constant reassurance from staff to keep them focussed on their meal. However, as staff were also required to take meals through to those people who chose to eat in their rooms, this reassurance was not always available. This led to increased levels of distress for the person and also

negatively affected the dining experience for other people who were eating at that time. Once the meals had all been served and staff were available they were then able to provide the necessary level of support needed and the person settled down and began to enjoy their meal in a more relaxed and enjoyable atmosphere. It was felt that the distress experienced could have been avoided had another member of staff been present at this time.

On the second floor we found that the tables were set with tablecloths, cutlery, cups and saucers and condiments creating a more refined dining experience. The food served looked hot and appetising. We asked the people whether they enjoyed their meals and all told us that they had done. We also saw that refreshments and snacks including biscuits and fruit were offered throughout the day. People living in the home told us they felt they had enough to eat and drink and if they wanted more all they needed to do was ask.

We saw that the home monitored people's weights on a monthly basis and if they found that people had lost weight they would then be weighed weekly. We saw the home used the Malnutrition Universal Screening Tool (MUST) to help assess people's nutritional needs and determine what 'plan' a person should be on in relation to their current weight and body mass index (BMI). The MUST was also used to inform the staff when a referral to the GP or dietician was necessary to fully assess a person's nutritional status. We did note however that the MUST was not used alongside a person's weight in their files. We discussed this with the manager and they agreed to incorporate the MUST tool in to the care files to ensure that a person's BMI was calculated following each weighing.

We saw people's health needs were met. We looked at people's care records and saw that the manager and care staff were quick to contact the appropriate health care professional should they notice that a person was either unwell or that their health needs had changed. All visits or meetings were recorded in the person's care plan with the outcome for the person and any action taken. We saw evidence that individuals had input from their GP's, district nurses, chiropodist, opticians and dentists. A visiting health and social care professional told us "If I make a requirement on a person's action plan it is always actioned properly and in a timely manner. My opinion is respected by the home."

Is the service effective?

We saw that the each person had a patient passport.
Patient passports explained how to care for people should

they be admitted to hospital. These included key
information regarding whether the person had any allergies
or behaviour traits that hospital staff needed to be aware of
so they could provide more personalised care.

Is the service caring?

Our findings

Throughout the inspection we saw that staff treated people living in the home in a respectful and caring manner. We observed positive interactions between the staff and the people they cared for and saw they clearly had a good rapport with the people living in the home. We saw that staff knew how to engage with people when they were agitated, confused or showed signs of distress. Care staff were skilled at knowing when to distract, redirect, offer reassurance or walk away to achieve the desired result and enable the person to continue with their day.

We saw that staff knew how to engage with people in different ways. They knew who they could laugh and share a joke with and also who they needed to communicate with in a more formal way. People living at the home told us that staff always treated them in a caring way. One person told us “The staff are always gentle with me” and “You can tell they care.” Others said that the staff were “Caring” and “Fun” and were good with all the people living in the home.

A member of staff told us “All the staff genuinely care about the residents and they shouldn’t be here if they don’t.” Another said “I like to make sure that people know someone is there for them if they need us and to give them the reassurance so they know we are around.” A visiting health care professional told us “The staff here are lovely, they take me to the patient and the communication is always good.” This was supported by another, who said “The home offers a good level of care and the staff are committed and show empathy towards people. I think they are lovely.” One relative told us “We are happy with the care [Name] receives. When we visit [Name] is always clean and well fed and we feel the home is meeting their needs” and “A hairdresser comes to the home and does his hair and the podiatrist also comes and looks after his feet.”

We saw that the home had made attempts to capture personal information about the people they cared for from those who were closest to them. One relative told us “We completed a questionnaire about [Names] like and dislikes and their life history.” This enabled the homes care staff to develop a better understanding of how to care for the people living in the home.

The manager told us they tried to support people’s cultural and religious needs whenever they could. They told us that

a vicar and a priest visited the home at least once per month. This was particularly important to people living in the home who were now unable to attend church, but still wanted to practice their chosen religion and feel part of the religious community.

On arrival two people who lived in the home were sitting in the lounge on the ground floor. One of them explained to us that their hearing aid had broken and this was very upsetting for them. They told us that the staff had made an appointment to have it repaired immediately. Later on in the day they told us they were very pleased as the hearing aid had been returned and that they could now have a conversation with their friends and staff. This showed the homes staff responded quickly to ensure that people’s communication needs were met.

There was information about advocacy services available to people who lived at the home. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them. The manager told us that two of the people living in the home had advocates to help manage their finances and that this was available to anybody who either did not have family to provide a voice or had stated they did not want family involvement. Another person used a solicitor to ensure that their money was safely managed and spent in a way that they would be happy with.

On the day of the inspection we saw that people were encouraged to do things for themselves if they could. People were able to move around the home freely and could also leave the home if they were able to do so. The homes staff actively encouraged people to continue to access the community as frequently as they liked. We also saw that one person was able to self-medicate enabling them to maintain control over this aspect of their own life. This was monitored closely by the manager to ensure that their medicines were taken as prescribed. At lunchtime staff only assisted people if they indicated they would like some help or if they looked as though they were struggling. Staff told us that they always encouraged people to be as independent as possible. One member of staff said “I always persevere with resident’s who have dementia, allowing them time to answer questions and I keep trying to allow them to continue to make as many choices as they can.”

During the inspection we saw that people’s friends and relatives were welcomed by the manager and staff and

Is the service caring?

were able to visit the home as frequently as they wanted. Some relatives spent time in the home and others took their relative or friend out for a drive or to visit shops in the town centre. People living in the home told us that they felt

their families and friends were made to feel welcome by the homes staff. However one relative said “They don’t offer us a drink when we visit, although I would rather they spent the time caring for the people living here.”

Is the service responsive?

Our findings

Prior to moving to the home all people had a pre-admission assessment. This was carried out by the manager and usually one other member of staff to ensure they were both satisfied they could meet the needs of the person before offering them a place at the home. People were continually assessed during their time in the home and if the manager felt they could not meet a person's needs then they would look to move people to a more appropriate home. From this initial assessment people's dependency levels were determined and more detailed care and support plans and risk assessments were developed. This included, for example, information on a person's mobility, nutritional needs, personal care and medicines.

Care files included information on people's likes and dislikes, how they would like their care to be delivered and what was important to them. We saw detailed information in one person's care plan explaining how they liked to have their hands and nails cleaned and how it was important to ensure they were wearing clothing that was colour coordinated and they were always well presented.

People who were assessed to be at increased risk of falls, weight loss, pressure sores or who displayed behaviours that challenged themselves or others had monitoring charts put in place. Most of the charts we viewed contained accurate recordings. However, we saw that fluid charts were not tallied, nor was there any advice present about how much fluid a person should be consuming and what steps to take if they were found to be falling below this level. The manager told us they would address this matter with the staff team and ensure that the guidance on this was clear.

Care plans were reviewed on a monthly basis and updated based on the information shared during handovers and also the information recorded in people's daily records. We saw that one person's health had deteriorated and they were now cared for in bed. The home had put a temporary care plan in place to ensure staff knew how to care for the person during this period of illness. The manager told us that if they made a full recovery then they would revert back to the previous plan. This showed that staff were responsive to people's changing needs.

The manager told us that they encouraged people to be as active in the community as they could be. They told us that they organised bus trips to Scarborough and garden centres and had also arranged for people to attend a recent carol concert. They told us that some people went out by themselves, either to do some shopping or have a drink at the local café and that one person attended the yacht club. One person living at the service told us "I go out when I want to, I get on the bus."

The home employed an activity coordinator who worked for 15 hours per week across 5 days. They carried out activities such as Bingo, knitting, arts and crafts, skittles and quoits. However, all of the people we spoke with told us they would like more activities. They told us that since the activity coordinator had been off work the activities had all but stopped and "There isn't much to do" although they did tell us about an exercise class on a Tuesday afternoon that they all enjoyed.

We recommend the type and availability of activities is reviewed to ensure that all people living in the home are provided with an opportunity to engage in an activity of their choice.

The service had policies and procedures in place to effectively manage any complaints that they received. We found that the home did not receive many complaints but the complaints and compliments they did receive were recorded correctly. We saw that complaints were fully investigated and that the complainant always received a prompt response. There was evidence that appropriate action had been taken in response to complaints received.

A copy of the complaints procedure was available in the reception area of the home. All of the people we spoke with said that if they had any concerns they would speak to either the manager or a member staff. From our discussions with staff we found they knew how to support people to make a complaint if they needed to. One member of staff told us "If a resident wanted to make a complaint I would take them somewhere quiet so we could discuss it in private. I would then contact my manager or take it higher if I needed to."

We also saw that questionnaires were placed at the front of the home to provide people with the opportunity to feedback any concerns they may have regarding the how the home was managed or feedback any suggestions for improvements to be made. The manager also produced a

Is the service responsive?

quarterly newsletter to provide relatives and friends with information regarding what was happening in the home, upcoming events and people's birthdays. This helped people who lived at the home and others to keep up to date with events at the home.

Is the service well-led?

Our findings

We found that the home had completed an annual audit in January each year. This audit monitored the number of complaints, incidents / accidents, safeguarding alerts and also briefly reviewed any policies and procedures to ensure they were all up to date. However the audit did not include any lessons learnt or what steps had been taken to prevent further accidents or incidents re-occurring. We did not see any evidence that audits in relation to infection control, medicines, food, care plans, training and health and safety were been carried out on a regular basis. This meant that the home did not have effective systems in place to assess, monitor and improve the service.

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

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager who was not registered with the Care Quality Commission (CQC). However, they had submitted an application for registration. The new manager had been appointed in September when the previous manager had left the service.

The manager informed us that they had inherited a staff team with a backlog of out of date training and supervisions. They also told us that a number of care plans required updating to ensure that they were reflective of people's current needs. They informed us that they had completed an environmental audit across the home to determine where improvements needed to be made and from these audits had devised a business plan to help manage the implementation of the required improvements. The manager was looking forward to the challenges ahead and felt they had sufficient support from the general manager and the registered provider to rectify the current issues.

Services such as Sandy Lane Hotel that provide health and social care to people are required to inform the CQC of important events that happen in the service. We found that although the manager had informed the CQC of some significant events they had not informed us of the DoLS

authorisations that they currently had in place for two of the people living in the home. This was a breach of regulation and has been addressed in another part of the report.

People told us that the manager was approachable and supportive and they could go to them with any concerns. One member of staff said "I feel well supported by [Name]. We have a good relationship and [Name] is very approachable." Another said "I'm happy here, I feel well supported by the team." This view was shared by other members of staff, relatives and the people living in the home.

Staff also told us they now received formal supervision every two months and also attended staff meetings. This provided them the opportunity to discuss any issues of concern, address any training requirements, discuss any changes in people's needs and enable the homes management team to share any information of importance or address any issues within the home. One member of staff told us "I go to staff meetings once a month, everybody can voice their opinion."

We saw that annual appraisals had been completed for all members of staff. However, we found that these did not fully address some of the issues we had found in relation to training. We saw that despite some of the homes staff not having completed any training in 2015, their appraisal stated that no training was currently required. This meant the appraisals were not been utilised to fully identify areas in which the staff team could be developed. We saw that the appraisals had been carried out by the deputy manager and when we checked the training schedule we saw that they had not completed any training on how to effectively carry out a supervisory role.

We recommend that the service ensures staff receive effective supervision and appraisal.

We were told that questionnaires were sent out every six months to people living in the home and their families regarding the homes menus. However the only surveys present in the homes quality assurance files were from 2014. We saw that questionnaires were available at the entrance of the home and that people were encouraged to feedback any concerns they might have regarding how the home was managed. However it did not appear that this facility was currently been utilised.

Is the service well-led?

We discussed the culture of the home with the manager and general manager. They told us that they “Focus on delivering quality care” and “We aim to make people feel important.” They also said “We think of the residents as

part of the family” and “We care for people like you would care for your own family.” They told us that their own relatives had stayed at the home and that some of the staff had family living in the home at this time.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

People who use the service were not protected from risks associated with the improper storage, administration and disposal of medicines. People were also not protected from risks associated with not assessing the risk of and preventing, detecting and controlling the spread of infections.

Regulation 12 (1)(2)(g)(h)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

People who use services and others were not protected against the risks associated with unsafe or unsuitable equipment because of inadequate maintenance.

Regulation 15 (1)(a) (2)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

People who use the service were not protected from the risks associated with receiving care from staff who were not properly trained to carry out the duties they are employed to perform.

Regulation 18 (1)(2)(a)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

This section is primarily information for the provider

Action we have told the provider to take

The registered provider failed to notify the CQC of an application made in relation to depriving a service user of their liberty.

Regulation 18 (d)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider did not have in place effective systems to assess, monitor and improve the quality and safety of the services provided in the carrying out of the regulated activity.

Regulation 17 (1)(2)(a)(b)